State of New Hampshire
Department of Health and Human Services
July 2018 – December 2018 Capitation Rate Development for the NHHPP Transitional Population

Prepared for:
The State of New Hampshire
Department of Health and Human Services

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I. EXECUTIVE SUMMARY

This report documents the development of the July 2018 – December 2018 managed care organization (MCO) capitation rates for individuals transitioning from New Hampshire's Medicaid Care Management (MCM) program to the New Hampshire Health Protection Program (NHHPP) Premium Assistance Program (PAP). The New Hampshire Department of Health and Human Services (DHHS) retained Milliman to calculate, document, and certify its capitation rate development. We developed the capitation rates using the methodology described in this report.

Our role is to certify that the July 2018 – December 2018 capitation rates produced by the rating methodology are actuarially sound to comply with Centers for Medicare and Medicaid Services (CMS) regulations. We developed actuarially sound capitation rates using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), CMS, and federal regulations to ensure compliance with generally accepted actuarial practices and regulatory requirements.

The NHHPP transitional population capitation rates are for individuals who lose eligibility for standard Medicaid, but gain eligibility for PAP. The NHHPP transitional population capitation rates provide coverage while these individuals finalize enrollment in a Qualified Health Plan (QHP) under the PAP. Members are expected to be enrolled in the NHHPP transitional population for less than two months prior to their enrollment in a QHP. With the transition of the Premium Assistance Program population into Medicaid managed care on January 1, 2019, the plan selection period between Medicaid and the QHP enrollment (and vice-versa) is no longer necessary. Therefore, the transitional population capitation rates will no longer be required as of that date.

The July 2018 – December 2018 capitation rate for the transitional population also provides a framework for financial risk protections that safeguard both the MCOs and the state and federal governments from potential overestimation or underestimation of the MCO capitation rates compared to the health care needs of the transitional population. These financial protections are similar to protections that were available for the Bridge Program under NHHPP and for the NHHPP transitional population from January 2016 – June 2018.

JULY 2018 – DECEMBER 2018 CAPITATION RATE CHANGE

Table 1 shows the statewide rate change from the SFY 2018 capitation rates to the July 2018 – December 2018 transitional population capitation rates. Appendix F shows a summary of the rate change.

Table 1
New Hampshire Department of Health and Human Services
July 2018 – December 2018 NHHPP Transitional Capitation Rate Change
Based on Projected July 2018 – December 2018 MCO Enrollment

Population	SFY 2018 Capitation Rate	July 2018 – December 2018 Capitation Rate	Percentage Change
NHHPP Transitional Population	$429.28	$509.37	18.7%

Table 2 provides a summary of the impact of these program changes and calculates a 9.8% rate increase excluding the impact of the program changes from SFY 2018 to July 2018 – December 2018.

Table 2
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
Summary of July 2018 – December 2018 Capitation Rate Change Components

Rate Component	Rate Change	6 Months Dollar Impact
Rate Change Prior to Program Changes	**9.8%**	**$292,000**
July 2018 – December 2018 program changes:		
Opioid Addiction Treatment Cost Trend Adjustment	8.4%	250,000
CMHC Temporary Fee Schedule Increase	0.4%	11,000
Implementation of Behavioral Health Crisis Treatment Center	0.0%	0
White Mountain Community Center	0.0%	1,000
CMHC Workforce Expansion Directed Payment	0.0%	0
Total Program Changes	**8.8%**	**262,000**
Total SFY 2018 to July 2018 – December 2018 rate change	**18.7%**	**$554,000**

Please note that the Maternity Kick Payment development is no longer included in this report, since it is the same payment as that for the MCM population. The July 2018 – December 2018 Maternity Kick Payment is $2,838.56 per delivery. Please refer to the SFY 2019 MCM rate report dated May 14, 2018 for documentation of the Maternity Kick Payment rate.

We project an overall MCO medical loss ratio (MLR) of 86.9% for the NHHPP transitional population for July 2018 – December 2018, which includes:

- A 9.8% administrative cost allowance for the transitional population rate cell, as well as a 1.5% risk margin applied as a percentage of revenue prior to the CMHC directed payment and the premium tax allowance
- A 2.0% allowance for New Hampshire's premium tax

The projected MLR excludes the impact of the CMHC directed payment in both the numerator and denominator of the MLR calculation, which is consistent with the treatment of directed payments in federal MLR calculations.

The capitation rates shown above are based on our projections of the MCO enrollment for July 2018 – December 2018. We developed these membership projections by looking at historical NHHPP transitional population enrollment since the NHHPP bridge program ended. We also reviewed the NHHPP population enrollment in the context of the MCM low income adult rate cell.

It should be emphasized that capitation rates are a projection of future costs for an efficient MCO, based on a set of assumptions. Actual MCO costs will be dependent on each MCO's situation and the extent to which future experience conforms to the assumptions made in the capitation rate development calculations.

REPORT STRUCTURE

Appendices A through E document the development of the July 2018 – December 2018 capitation rates. Appendix F calculates the capitation rate change from the SFY 2018 rate period. Appendix G calculates the fiscal impact of the July 2018 – December 2018 capitation rates based on projected July 2018 – December 2018 enrollment levels. Appendices H, I, and J provide additional supporting exhibits. The actuarial certification of the July 2018 – December 2018 NHHPP transitional population capitation rates is included as Appendix K.

Section II provides an overview of the methodology, including a summary of changes made to the SFY 2018 methodology. Section III documents the capitation rate base data and medical cost projections. Section IV summarizes final capitation rate adjustments for all rate cells, including various program adjustments and the administrative / margin allowance. Section V of the report provides information regarding the assignment of service categories. Section VI discusses issues related to the CMS rate setting checklist. Section VII includes comments on items related to the 2018-2019 Medicaid Managed Care Rate Development Guide.

DATA RELIANCE AND IMPORTANT CAVEATS

We used MCO encounter cost and eligibility data for July 2015 through December 2017, MCO financial data, historical reimbursement information, TPL recoveries, current fee schedules, and other DHHS and MCO information to calculate the NHHPP transitional population capitation rates shown in this report. This data was provided by DHHS and participating MCOs. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

We constructed several projection models to develop the capitation rates shown in this report. Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used in the July 2018 – December 2018 capitation rates due to differences in health care trend, managed care efficiency, provider reimbursement levels, and many other factors. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Milliman prepared this report for the specific purpose of developing July 2018 – December 2018 NHHPP transitional population capitation rates. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHHS. We understand this report may be shared with participating MCOs, CMS, and other interested parties. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This report should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of this report are consulting actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2017 apply to this report and its use.

II. METHODOLOGY OVERVIEW

This section of the report provides an overview of the July 2018 – December 2018 NHHPP transitional population capitation rate methodology and highlights program changes effective for July 2018 – December 2018.

The development of the capitation rates contained in this letter largely follows the methodology used for the MCM program. Due to the low volume of data for the transitional population, we relied on MCO encounter data for the MCM program's Low Income Adult rate cell.

Certain modifications were made to the development of the MCM capitation rates to arrive at the NHHPP transitional rates. These modifications include:

- We included an adjustment to account for differences in acuity between the Low Income Adults population and the Transitional population
- We included $2.36 PMPM in the capitation rates to account for the NHHPP chiropractic benefit

The administrative and margin load is consistent with the SFY 2019 MCM Low Income Adult rate cell (9.8%).

BASE DATA

We developed the July 2018 – December 2018 capitation rates using enrollment data and MCO encounter claims from SFY 2016 and SFY 2017.

- We used two years of base data to increase the credibility of the rate development calculation.
- We obtained MCO encounter data and sub-capitated expenditures directly from the participating MCOs. The July 2018 – December 2018 capitation rates include sub-capitated expenditures for services not capitated through an affiliated organization. For related entities, the July 2018 – December 2018 rates include actual encounter payments to providers for those services, when available. We removed administrative payments made by the MCOs to related parties from the encounter data. The MCOs also provided summarized provider incentive payments and settlements made outside of the claims data and these items were included in the base data.
- We obtained eligibility and MCM enrollment information from DHHS.

We believe the encounter data is of appropriate quality and completeness to use as the primary basis for developing actuarially sound rates for the NHHPP transitional population. We validated the MCO encounter data using the following process:

- We compared the submitted encounter data to quarterly financial data summaries provided by the MCOs. The quarterly financial data summaries included FFS and sub-capitated payments made by the MCOs to providers by rate cell, broad service category, and quarter. The financial data was not audited, but is certified by the MCO as accurate and complete.

- DHHS and Milliman provided an opportunity for MCOs to play a greater role in the base data validation for the July 2018 – December 2018 capitation rate development process. As we worked on the development of the July 2018 – December 2018 capitation rates, we provided MCOs with a series of detailed data summaries in order to further our understanding of the data, complete the validation process, and offer more transparency on the process leading to the capitation rates.

- Through this detailed review process, Milliman, DHHS, and the MCOs validated the encounter data for use in the capitation rate setting process.

We did not identify any material concerns with the quality or availability of the data with respect to total claims in aggregate, or our ability to allocate encounter data to major service categories. Our data reconciliation efforts are consistent with Actuarial Standard of Practice #23.

PROGRAM CHANGES FROM THE SFY 2018 CAPITATION RATE METHODOLOGY

The July 2018 – December 2018 capitation rate methodology reflects several major program changes from the SFY 2018 capitation rate methodology presented in our November 10, 2017 certification. The changes are as follows:

- Inclusion of a specific trend adjustment to recognize an increase in the number of members treated for opioid addiction and their related treatment costs

- Implementation of a temporary fee schedule increase for CMHC services

- Implementation of a Behavioral Health Crisis Treatment Center effective November 1, 2018

- Implementation of a change for White Mountain Community Center to FQHC Look-Alike (LAL) status

- Inclusion of a CMHC directed payment of $5 million across all programs for SFY 2019 to support workforce development

Any subsequent material program changes enacted by the legislature or DHHS would need to be factored into the July 2018 – December 2018 capitation rates as a rate adjustment.

METHODOLOGY

We used the following methodology to develop the NHHPP transitional population capitation rates:

1. Summarize SFY 2016 and SFY 2017 encounter experience data for the MCM low income adults rate cell

2. Calculate estimated statewide July 2018 – December 2018 NHHPP transitional population medical costs for all covered services

3. Adjust July 2018 – December 2018 projected medical costs for benefits not included in the base experience data, expected administrative expenses, margin, and premium tax

Sections III and IV of this report document the rate setting methodology in detail.

ACA INSURER FEE

The ACA places an annual fee on the health insurance industry. The fee is allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (e.g., the 2020 health insurer fee will be based on 2019 premium revenue). There is a moratorium on the health insurer fee for 2019. Market share is based on commercial, Medicare, and Medicaid revenue. CMS regulations require Medicaid managed care rates to include allowances for taxes like the ACA insurer fee because they are an unavoidable cost of doing business for Medicaid MCOs.

DHHS recognizes the need to fund payments related to the ACA health insurer fee that will be paid by the MCOs. Taxes, such as the ACA health insurer fee and related income tax impacts, are widely recognized as a reasonable and unavoidable cost of doing business for Medicaid MCOs and should be considered by the Medicaid actuary for inclusion in Medicaid managed care payments.

The MCO capitation rates documented in this report are actuarially sound prior to the application of the ACA health insurer fee provision. DHHS will recalculate capitation payments for each MCO based on the actual amount of the health insurer fee for each plan and make gross adjustment payments to the MCOs to appropriately fund the ACA health insurer tax and its related income tax impact. Although paid separately, the allocation for the ACA insurer fee is part of the actuarially sound MCO capitation rates.

RISK PROTECTION STRUCTURE

Given the uncertainty of estimating the future cost of the transitional population, DHHS will implement a framework for financial risk protections that safeguard both the MCOs and the state and federal governments from potential overestimation or underestimation of the MCO capitation rate, compared to the health care needs of the population. The risk mitigation provision for the July 2018 – December 2018 contract period includes a risk corridor.

The risk corridor provision protects against uncertainty in annual profit or loss results for the MCOs serving NHHPP members in the July 2018 – December 2018 contract period. DHHS and each MCO will share the financial risk of actual results that are above or below the 86.9% medical loss ratio (MLR) target as shown in Table 3.

Table 3
New Hampshire Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
Risk Corridor Program

Actual MLR Compared to Target MLR	MCO Share	DHHS Share
>3% below	10%	90%
1% - 3% below	50%	50%
1% below - 1% above	100%	0%
1% - 3% above	50%	50%
>3% above	10%	90%

RISK ADJUSTMENT OF CAPITATION RATES

The July 2018 – December 2018 NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

III. MEDICAL COST PROJECTIONS

This section of the report describes the projection of the MCO encounter data for all rate cells.

We used the following methodology to project the encounter data used in the calculation of the medical component of the capitation rates:

1. Summarize SFY 2016 and SFY 2017 MCO encounter base experience data for the MCM low income adults rate cell for the services covered for the NHHPP transitional population

2. Apply adjustments to the base data to project July 2018 – December 2018 NHHPP transitional population medical costs

3. Blend the projected SFY 2016 and SFY 2017 encounter data

Each of the above steps is described in detail below.

STEP 1: SUMMARIZE MCO ENCOUNTER BASE EXPERIENCE DATA

In this step, we summarize the encounter experience for SFY 2016 and SFY 2017 by rate cell and service category for the MCM low income adults rate cell.

Appendices A1 and A2 show the summarized SFY 2016 and SFY 2017 MCO encounter base experience data for each rate cell.

Base Data

We summarized detailed MCO encounter claims data with dates of service between July 2015 and June 2017, with dates of payment through December 2017 , and with the following specifications:

- The cost and utilization data reflect the claim header information for claims paid at the header level and line item detail for claims paid at the detail level

- Claims for FQHC and RHC providers reflect their normal prospective per encounter rates

- Prescription drug claims reflect gross ingredient cost and dispensing fees prior to any pharmacy rebates

- We excluded claims and eligibility data for the portion of any month when an individual had a stay longer than 15 days in an IMD

- We excluded hepatitis C, hemophilia and other high cost drugs (Carbaglu and Ravicti) as the MCOs are not at risk for these drugs for the NHHPP transitional population

Non-Covered Services Adjustment

MCOs are allowed to provide services not explicitly covered under the NHHPP program to beneficiaries in lieu of a covered service. As part of the capitation rate development process, the encounter data must be adjusted to remove any portion of the cost of in lieu of services that exceeds the cost of the corresponding covered service.

MCOs currently provide Medical Nutrition and Diabetes Self-Management services defined by procedure codes 97802, 97803, and G0108 with average unit cost of $19.20 per unit, using staff nutritionists. Alternatively, these services would be provided as a covered service by a physician in an office setting at the cost of $20.16 per unit (based on the Medicaid fee for 99201 office visit). This comparison shows that Medical Nutrition and Diabetes Self-Management services are cost effective. Therefore, we did not make any adjustment to the base period data for non-covered services.

Retroactive Eligibility and Enrollment Lag

Recipient enrollment in the FFS program can and does occur retroactively. When an individual applies and qualifies for Medicaid coverage, DHHS reimburses claims that occurred during the retroactive qualification period prior to their application. DHHS backdates the eligibility of the individual to accommodate the retroactive coverage.

The MCOs do not cover these retroactive enrollment periods. Retroactive claims were included in the data provided by DHHS. The enrollment data provided by DHHS excluded retroactive enrollment periods; therefore, a special adjustment was not necessary because we only summarized claims for individuals with non-retroactive enrollment records. Since the encounter data already excludes the retroactive eligibility period and enrollment lag, no adjustments were needed.

Eligibility Category Assignment

As discussed above, the base data for the NHHPP transitional population uses the MCM low income adults enrolled in the MCM program. As such, the SFY 2016 and SFY 2017 enrollment for the July 2018 – December 2018 NHHPP transitional population rates excludes MCM enrollees in the following categories:

1. NF resident rate cells
2. Community resident and other waiver rate cells
3. Behavioral health population rate cells

We identified and classified the low income adults using the eligibility codes found in the enrollment file provided by DHHS. Table 4 below shows the definitions we used for this rate cell. The rate cell assignment is done on a first of the month basis, consistent with capitation rate payment from MMIS.

Table 4
New Hampshire Department of Health and Human Services
New Hampshire Health Protection Program
Rate Cell Definitions

Rate Cell	Age / Gender Categories	Eligibility Category	Dual Status Code*	Other Criteria
Low Income Children and Adults	19 - 64	MAEM, MAEN, MAER, MAES, MAEU, MAFR, MAFU, MCER, MCEU, MCFR, MCFU, MCIE, MCN, MCRA, MCRF, ME12, ME4, MMER, MMEU, MMFR, MMFU, MMRA, MMRF, MP C, MP P, MPQC, MPQP, MCIS, MGIC, MGIE, MGIN, MGIP, MGIW	N	N/A

STEP 2: APPLY ADJUSTMENTS TO THE BASE EXPERIENCE DATA TO PROJECT JULY 2018 – DECEMBER 2018 MEDICAL COSTS

In this step, we apply adjustment factors to reflect differences between the base period data and the projected July 2018 – December 2018 NHHPP transitional population medical costs. We explain each adjustment factor in detail below.

Appendices B1 to B2 show adjusted and trended values for each rate cell, along with the detailed adjustment factors by service category.

IBNR Adjustment

We developed completion factors (CFs) by eligibility category and major service category for claims incurred in SFY 2016 and SFY 2017. Since we now have runout through December 2017, we determined that the SFY 2016 data was complete.

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the completion factors shown in Table 5 below. CREW calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order to measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate, and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually twelve) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods.

We applied a 1.05 underreporting adjustment to the SFY 2016 and SFY 2017 MCO encounter base experience data for CMHC services only. We developed this adjustment from information provided by several CMHCs who we identified as having outstanding unreported claims. We developed the underreporting adjustment in order to correct for data reporting issues between the CMHCs and as we understand there is not an actual reduction in services provided by the CMHCs.

Table 5 below shows the IBNR adjustment factors applied to the SFY 2016 and SFY 2017 experience data.

Table 5
New Hampshire Department of Health and Human Services
Incurred But Not Reported Claims Adjustment

Eligibility Category	Hospital Inpatient Services	Hospital Outpatient Services	Mental Health Center Services	Prescription Drugs	Professional and Other Services
SFY 2016 Encounter Data					
Low Income Children and Adults	1.000	1.000	1.050	1.000	1.000
SFY 2017 Encounter Data					
Low Income Children and Adults	1.009	1.007	1.052	1.000	1.005

Reimbursement Adjustment

We reviewed the MCO provider reimbursement levels in the MCM base experience period as a percentage of Medicaid fees to better understand MCO provider contracts and payment levels. The July 2018 – December 2018 NHHPP payment rates will be equivalent to the most recent Medicaid fee schedule. Therefore, it is appropriate to review the MCO's reimbursement levels in the MCM program.

Table 6 below shows the aggregate results from our analysis compared to previous reimbursement level assumptions.

Table 6
New Hampshire Department of Health and Human Services
MCO Reimbursement Levels

Service Category	Observed SFY 2017 Reimbursement Level	Previously Assumed Reimbursement Level
Hospital Inpatient – Other Services	102%	102%
Hospital Outpatient Services	102%	102%
Professional Services	102%	101%
Federally Qualified Health Center Services	100%	100%
Community Mental Health Center Services	100%	100%

We applied an adjustment factor to reflect recent changes in FFS provider reimbursement to both the FFS and encounter data. Our adjustment factors are based on a comparison of the Medicaid fees effective during the SFY 2016 and SFY 2017 base period to the most recent fee schedules provided by DHHS.

We used the DRG rate table effective October 2014 through October 2017 in conjunction with admit distributions to develop reimbursement adjustment factors. Table 7 shows a summary of the impact of the hospital inpatient pricing adjustment. On average, the impact is an increase of 1.9% increase for SFY 2016 encounter claims and a 2.0% increase for SFY 2017 encounter claims.

Table 7 New Hampshire Department of Health and Human Services Impact of Repricing for Hospital Inpatient Services Average Impact for Low Income Adults		
	Low Income Adults	
Benefit Category	**SFY 2016 Encounter Data**	**SFY 2017 Encounter Data**
Medical	1.010	1.010
Surgical	1.009	1.010
Maternity Delivery	1.000	1.002
Maternity Non-Delivery	1.071	1.081
Newborn	1.000	1.002
Psychiatric	1.033	1.026
Alcohol and Drug Abuse	1.094	1.051
Other	1.000	1.002
Total	**1.019**	**1.020**

We did not apply a specific reimbursement adjustment to estimate the reimbursement levels for hospital outpatient services since MCOs pay most outpatient services on a cost basis consistent with FFS reimbursement. We address increases to cost-based reimbursement in the trend development section of this report.

The reimbursement adjustment factors for professional and other services are based on a comparison of the Medicaid fees effective during the base period to the most recent fee schedules as of February 28, 2018 and change logs as of May 8, 2018. For each CPT and HCPCS code, we compared the current FFS amount to the corresponding amount in the fee schedules effective on the date of service. We then summarized the data by rate cell and service category to obtain the adjustment factors.

We adjusted claims for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to reflect the most recent per encounter rate at each facility. The SFY 2018 FQHC rates are 1.2% higher than the SFY 2017 rates and we assumed an increase of 0.8% from SFY 2018 to July 2018 – December 2018, with the exception of Manchester Community Health Center (MCHC). MCHC recently filed a request for rate change due to two separate changes in their scope of services. Following approval by DHHS, the per encounter rate was increased to $195.08 for SFY 2019. The impact of the change in per encounter rate for MCHC is reflected in the reimbursement adjustment factors.

Table 8 shows a summary of the impact of the reimbursement change for professional and other services. On average, we increased SFY 2016 encounter claims by 1.7%. We increased the SFY 2017 encounter claims by 1.4%. There is additional variation by rate cell based on the services used by the population in each rate cell.

Table 8 New Hampshire Department of Health and Human Services Impact of Repricing for Professional and Other Services Average Impact for Low Income Adults		
	Low Income Adults	
Benefit Category	**SFY 2016 Encounter Data**	**SFY 2017 Encounter Data**
Ambulatory Surgery Center	1.004	1.008
Office Visits	1.000	1.000
Preventive Medicine	1.065	1.057
Maternity	1.000	1.000
Certified Midwife	1.000	1.000
PT / OT / ST	1.000	1.000
Psychiatric and Substance Abuse	1.001	1.015
Radiology and Pathology	1.000	1.000
Home Health and Private Duty Nursing	1.000	1.000
Ambulance	1.000	1.000
Non-Emergency Transportation	1.000	1.000
Opioid Treatment Program	1.000	1.000
Federally Qualified and Rural Health Clinics	1.056	1.044
Adult Medical Day Care	1.000	1.000
Personal Care	1.000	1.000
Durable Medical Equipment	1.002	1.000
Other	1.029	1.026
Total	**1.017**	**1.014**

We completely repriced claims for CMHC services at the current FFS fee schedule to calculate the reimbursement level. We also incorporated known fee changes not included in the current fee schedules.

Medical Trend from SFY 2016 and SFY 2017 to July 2018 – December 2018

We developed trend rates from SFY 2016 and SFY 2017 to July 2018 – December 2018 by type of service using our experience with similar populations in other states and CMS projected trends. Table 9 below summarizes the medical trend rate assumptions by major service category.

Table 9 New Hampshire Department of Health and Human Services Annual Trends from SFY 2016 to July 2018 – December 2018		
Service Category	**Utilization Trend**	**Unit Cost Trend**
Hospital Inpatient	0.00%	0.42%[1]
Hospital Outpatient	2.00%	1.20%
Professional	1.00%	0.00%
Community Mental Health Center	1.00%	0.00%
Other Services	1.00%	0.00%

[1] *Unit cost trend for hospital inpatient services is applied as a one-time allowance for the expected 0.85% increase in DRG reimbursement on October 1, 2018 (not as an annual trend rate).*

Although hospital inpatient, professional, and other services are repriced using the October 2017 DRG rate table and the 2018 fee schedule, we also made a trend adjustment to account for expected changes in reimbursement levels in July 2018 – December 2018. For hospital inpatient services, we estimated the expected October 2018 DRG weight update to be an increase of 0.85% based on our review of historical DRG weights. We applied the 0.85% DRG weight increase as a 0.42% adjustment since it impacts only the last three months of the July 2018 – December 2018 rate period. For professional and other services, we assumed no fee schedule changes would be implemented during July 2018 – December 2018. DHHS does not anticipate making mid-year capitation rate changes if mid-year FFS reimbursement changes do not vary materially from our assumptions.

Hospital outpatient reimbursement changes are tied to changes in each hospital's operating cost. We developed the 1.2% annual trend for hospital outpatient services by reviewing the average annual change in the Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for hospital services from CY 2015 to CY 2017 (Series ID PCU622---622---). The Hospital PPI is a measure of hospital revenue changes that can also be used as a proxy for operating cost changes because the national average operating margins for hospitals are relatively stable from year to year.

Prescription Drug Trend from SFY 2016 and SFY 2017 to July 2018 – December 2018

Pharmacy trend assumptions are based on a combination of historical New Hampshire Medicaid data analysis, Milliman research on utilization and cost trends, and publicly available trend reports and forecasts.

Our prescription drug trend model uses the most recent 12 months of available MCM low income adult data (December 2016 – November 2017) as the base period for our projections. Given the constantly changing prescription drug market, it is critical to project trends using the most current available data.

The final trends are calculated as the ratio of the average drug costs in the projection period (July 2018 – December 2018) compared to the average drug costs in the rate setting base period (SFY 2016 and SFY 2017). Trends were calculated for brand, generic, and specialty drugs separately for utilization and unit cost. Projected values are estimated using the prescription drug base period data (December 2016 – November 2017) as a starting point and applying anticipated shifts and trends. Each component of pharmacy trend is documented below.

Since hepatitis C, hemophilia, and other high cost drugs (Carbaglu and Ravicti) are carved out of the NHHPP transitional population rates for July 2018 – December 2018, we excluded these drugs from our prescription drug trend development. Appendix J contains a list of NDCs for the excluded drugs.

Brand Patent Loss:

When a brand drug loses patent, utilization shifts from the brand drug to new generic alternatives. In our analysis, we shifted utilization for brand drugs that recently lost patent or are expected to lose patent in the projection period. We included known patent expirations through the end of 2018 (later expirations were excluded due to the uncertainty of the timing of patent expirations further out in the future). Our utilization shift assumptions are based on Milliman research of how quickly historic brand utilization converts to generic in each month after a patent expires. Similarly, we used assumptions for what the cost of the new generic drug would be relative to the current brand drug price. Major brand drugs that have already lost or are expected to lose patent between the base period and the projection period include the following drugs:

- Adcirca
- Byetta
- Lexiva
- Remicade

- Remodulin
- Rituxan
- Sensipar
- Treximet
- Viagra
- Viread
- Xolair

Cost per Script Trends:

Projected costs per script in December 2017 (the first month of the projection) are generally based on the average costs per script in the most recent three months of the experience data (September 2017 – November 2017), adjusted for any anomalies in the data. These costs are trended forward using separate cost trend assumptions for brand, generic, and specialty products, including class-specific trend assumptions for classes with demonstrably different trend patterns in recent months, based on AWP price history in New Hampshire claims experience data.

The cost per script trends are based on an analysis of historical average wholesale price (AWP) data. We mapped AWPs from Medi-Span by NDC and analyzed the annual trends over the past several quarters, using a fixed market basket of drugs from the transitional population's pharmacy claims experience. We also used public industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", to validate these unit cost trends.

Note that the overall average unit cost trend factor resulting from our trend analysis for certain rate cells and drug classes is above (or below) the targeted prospective unit cost trend used in our trend analysis to the extent that the September 2017 to November 2017 experience that we used as the starting point for the unit cost projections is above (or below) the SFY 2016 and FY 2017 base period unit cost experience.

Brand Cost Trends

We analyzed AWP trends for the brand drugs used by MCM low income adults. Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using transitional population data, we assumed a default brand annual unit cost trend of 8.0%. We varied trends from this default for several classes though, based on variations for classes with typically higher or lower than average trends. Table 10 shows the classes for which we used a unique trend value:

Table 10 New Hampshire Department of Health and Human Services Annual Brand Unit Cost Trends for Specific Therapeutic Classes	
Therapeutic Class	**Annual Brand Unit Cost Trend**
Acne Products	3.0%
Anaphylaxis Therapy Agents	12.0%
Anticonvulsants - Benzodiazepines	12.0%
Antipsychotics - Misc.	18.0%
Diagnostic Tests	3.0%
Insulin - Long Acting	2.0%
Insulin - Short / Intermediate Acting	12.0%
Opioid Partial Agonists	6.0%
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	15.0%
Combination Contraceptives - Oral	5.0%
Sympathomimetics	5.0%
Stimulants - Misc.	12.0%
Antidementia Agents	15.0%
Anticonvulsants - Misc.	12.0%
Scabicides and Pediculicides	20.0%

Generic Cost Trends

Generic drugs typically have only modest price increases. While generic trend increases were higher than usual during much of 2014 - 2016 due to ingredient shortages, changes to legislation, and consolidation of generic manufacturers resulting in reduced competition, this pattern has slowed, and generic trends have been returning to more typical levels in recent quarters. We expect this slowing of generic trends to continue in the near future.

Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using MCM low income adult data, we assumed a default generic annual unit cost trend of 1.5%. Similar to brand unit cost trends, we varied trends from this default for several classes, based on variations in the data for classes with typically higher or lower than average trends. Table 11 shows the classes for which we used a unique trend value:

Table 11 New Hampshire Department of Health and Human Services Annual Generic Unit Cost Trends for Specific Therapeutic Classes	
Therapeutic Class	**Annual Generic Unit Cost Trend**
Acne Products	3.0%
HMG CoA Reductase Inhibitors	0.0%
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	0.0%
Soluble Tumor Necrosis Factor Receptor Agents - Monoclonoal Antibodies	3.5%
Stimulants - Misc.	10.0%
Phenothiazines	8.0%
Scabicides and Pediculicides	20.0%

Specialty Cost Trends

Specialty drugs continue to be a major contributor to overall pharmacy trends. There is an increase in overall average pharmacy costs due to an increased mix of specialty treatments; specialty drugs tend to be much higher cost than non-specialty medications, so as utilization of specialty products increases, the average price of all drugs increases. AWP trends for specialty drugs are also significant, and are currently expected to be somewhat higher than non-specialty brand cost trends.

Based on a combination of Milliman research, industry trend reports, such as the "Express Scripts 2017 Drug Trend Report", and the historical AWP trends using New Hampshire data, we assumed a default specialty unit cost trend of 9.5%. While historical unit cost trends, including high-cost pipeline drugs for the specialty category, have been below 9.5%, this assumption includes an allowance for additional high-cost pipeline drugs above those reflected in the historical claims data used in the trend analysis. We varied unit cost trends from this default for several classes, based on variations in the data for classes with typically higher or lower than average trends. Table 12 shows the classes for which we used a unique trend value:

Table 12
New Hampshire Department of Health and Human Services
Annual Specialty Unit Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Annual Specialty Unit Cost Trend
Cystic Fibrosis Agents	35.0%
Soluble Tumor Necrosis Factor Receptor Agents / Anti-TNF-alpha - Monoclonoal Antibodies	17.0%

Changes in Utilization:

Utilization levels for each month in the projection period was based on the utilization level for the same month in our base period, projected forward based on the utilization trend assigned to the therapeutic class. For example, December 2017 utilization was projected by trending December 2016 utilization using the applicable utilization trend assumptions, January 2018 utilization was projected by trending January 2017 utilization using the applicable utilization trend assumptions, and so on. This method accounts for seasonality differences in each month.

Additionally, the most recent three to six months of the experience data were used to determine the appropriate brand / generic mix of utilization for each therapeutic class, adjusted for anomalies as needed. By using the most recent three to six months of data to set the brand / generic mix, the projection reflects the impact of the MCO management of the PDL.

Generally, we have observed very flat utilization trends among Medicaid populations. As such, we generally used 0.0% utilization trends for both brands and generics. There are a few specialty classes, however, that have been growing significantly and are expected to grow in the future based on our analysis. Therefore, we applied non-zero utilization trends to a few specialty classes, as seen in Table 13 below:

Table 13 New Hampshire Department of Health and Human Services Specialty Utilization Trends for Specific Therapeutic Classes	
Therapeutic Class	**Specialty Trend**
Antineoplastic Enzyme Inhibitors	10.0%
Antiretrovirals	-5.0%
Growth Hormones	5.0%
Hematopoietic Growth Factors	5.0%
Multiple Sclerosis Agents	3.0%
Soluble Tumor Necrosis Factor Receptor Agents / Anti-TNF-alpha - Monoclonoal Antibodies	15.0%
Pulmonary Hypertension – Endothelin Receptor Agonists	5.0%

Note that while flat or positive prospective utilization trends are used in our trend analysis in nearly all cases, the overall utilization trend factor resulting from our trend analysis for certain rate cells and drug classes is above (or below) the targeted prospective trend to the extent that the December 2016 – November 2017 utilization is above (or below) the SFY 2016 and SFY 2017 base data utilization.

Summary of Drug Trends by Eligibility Category:

Table 14 shows a summary of the drugs trends for SFY 2016 and SFY 2017, respectively.

Table 14 New Hampshire Department of Health and Human Services Annual Prescription Drug Trends from SFY 2016 to July 2018 – December 2018							
	Utilization Trend			**Unit Cost Trend**			
Eligibility Category	**Generic**	**Brand**	**Specialty**	**Generic**	**Brand**	**Specialty**	**PMPM**
SFY 2016 to July 2018 – December 2018							
Low Income Adults	-2.1%	0.1%	-1.2%	0.2%	3.4%	22.1%	7.3%
SFY 2017 to July 2018 – December 2018							
Low Income Adults	-1.4%	0.5%	-0.9%	5.2%	2.8%	22.5%	9.2%

Aggregate pharmacy trends are lower than the trends included in recent rate development years. This largely results from utilization levels that decreased 3.0% between SFY 2016 and SFY 2017, with these negative trends continuing through November 2017. The persistent negative trends in the recent data partially explains the current projected pharmacy trend levels since our projections start from a lower point than what is included in the base experience period underlying the capitation rates.

It is also important to note that the shift to generic drugs further reduces the projected PMPM drug trends by 1.0%.

Comparison to CMS Office of the Actuary Trends

We did not rely on a strict trend calculation based on observed MCM low income adult or transitional population encounter data trends when developing trend assumptions for the July 2018 – December 2018 rate development. Instead, we developed the trend assumptions based on forward-looking considerations as described above. The July 2018 – December 2018 capitation rates are based on a blend of SFY 2016 and SFY 2017 base data.

We also compared our overall trend assumptions to the national Medicaid benefit expenditures per enrollee estimates included in Table 19 of the 2016 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary. Table 15 summarizes federal fiscal year (FFY) 2016 – FFY 2019 expenditure projections and trends for the Child, Adult, Aged, and Disabled eligibility categories. This time period is generally consistent with the base data period and rate period used to calculate the July 2018 – December 2018 NHHPP transitional population capitation rates. Note that the Aged and Disabled eligibility categories include a significant amount of costs related to long term services and supports (LTSS); therefore, the services included may not be as representative compared to current NHHPP covered services that exclude LTSS.

Table 15
Summary of National Medicaid Benefit Expenditures per Enrollee Estimates
Table 19 of the 2016 Actuarial Report on the Financial Outlook for Medicaid
Published by the CMS Office of the Actuary

Federal Fiscal Year	Non-Disabled Children	Non-Disabled Adults	Aged[1]	Disabled[1]
2016	$3,458	$5,215	$14,451	$20,082
2019	$3,939	$6,067	$16,294	$22,899
Average Annual Trend	**4.4%**	**5.2%**	**4.1%**	**4.5%**

[1] *Note that the Aged and Disabled eligibility categories include a significant amount of costs related to long term services and supports (LTSS; therefore, the services included may not be as representative compared to current MCM covered services that exclude LTSS.*

The combined annual trend rate across all services applied from the SFY 2016 and SFY 2017 base period to the July 2018 – December 2018 rate period for the NHHPP transitional population was roughly 5.8%. This trend includes utilization and unit cost trend across all services and also includes the impact of the repricing adjustments to hospital inpatient and professional services. Therefore, at a high level, the overall average annual trend rate we applied is somewhat higher then CMS projections due to higher pharmacy trends and the trend adjustment for the opioid addiction population.

Managed Care Savings Adjustment

The managed care savings adjustment reflects the medical cost savings generated through MCO care management activities. The managed care savings adjustment is to reflect targeted initiatives for the transitional population in July 2018 – December 2018. DHHS identified one priority for MCO medical cost reductions in July 2018 – December 2018 compared to the SFY 2016 and SFY 2017 base periods:

1. ***Hospital unit cost reductions:*** We observed that, on average, the MCOs contract with hospitals at approximately 102% of the New Hampshire Medicaid fee schedule. We compared the observed hospital contracting level of each MCO and concluded it was attainable for the MCOs to reduce the average hospital contracting factor by 0.5%. Therefore, we applied a 0.5% managed care savings factor to all hospital inpatient and hospital outpatient costs in the MCO encounter data.

Pharmacy Rebate Adjustment

The pharmacy rebate adjustment reflects a cost adjustment for prescription drugs to account for rebates the MCOs collect. The SFY 2016 and SFY 2017 encounter data does not reflect rebates the MCOs will collect outside of the claims payment system. As such, we include a reduction of 3.25% to estimate the amount of gross drug costs that will be collected in post-sale rebates. We based this estimate on a review of recent MCO prescription drug rebates after the MCOs started managing the PDL, as reported in quarterly financial data.

Private Duty Nursing Adjustments

Effective April 1, 2016, DHHS implemented a reimbursement increase for private duty nursing (PDN) providers to meet the higher demand for nursing support for nights and weekends, as well as be competitive in the New Hampshire nursing marketplace. The Department's intent is to improve nursing salary rates, with rate reimbursement increases depending on nursing level and time of day / acuity, for skilled nurses during the day, night, and weekends, as well as afford a competitive level of compensation for intensive nursing skills for members requiring acute care in the home. The reimbursement increase ranges from 25% for day services and 39% to 46% for nights, weekends, and intensive nursing.

We reviewed encounter data for SFY 2016 and identified RNs and LPNs using the S9123 and S9124 Current Procedural Terminology (CPT) codes, respectively, as instructed by DHHS. We determined the capitation rate impact using the proportion of PDN services. We included a 5% utilization adjustment for the expected increase in service hours provided. The impact of the reimbursement change is included in the reimbursement adjustment factors, while the PDN specific adjustment includes the utilization component only. We applied the adjustment to the first nine months of the SFY 2016 data because the PDN changes were made on April 1, 2016.

Please note that the NHHPP transitional population base experience data did not contain any claims for CPT Codes S9123 and S9124. Therefore, the adjustment factor is 1.0000.

Non-Emergency Medical Transportation Claims Adjustments

We adjusted historical non-emergency medical transportation (NEMT) services in the encounter data to reflect utilization increases beyond expected levels. Recent NEMT costs have increased significantly, compared to the SFY 2016 and SFY 2017 base period.

We developed the adjustment by reviewing more recent MCO cost experience for the non-opioid addiction treatment population and determined the impact on the base period experience. The NEMT cost adjustment related to the opioid addiction treatment population is discussed in the "Opioid Addiction Treatment Trend Adjustment" section later in this report. Table 16 shows the adjustments factors by eligibility category.

Table 16
New Hampshire Department of Health and Human Services
Medicaid Managed Care Program
Non-Emergency Medical Transportation Adjustment

Eligibility Groupings	SFY 2016	SFY 2017
Low Income Children and Adult, Foster Care	1.043	1.162

STEP 3: BLEND THE PROJECTED SFY 2016 AND SFY 2017 DATA

In this step, we blend the projected July 2018 – December 2018 medical cost using the SFY 2016 and SFY 2017 encounter base experience. We blend the data for each rate cell with a 50% weight assigned to SFY 2016 base data projections and a 50% weight assigned to SFY 2017 base data projections. Blending the two base year projections increases the credibility of the capitation rate.

Transitional Population Experience Adjustment

We made an experience adjustment to replace the age / gender and behavioral health population adjustment used in prior years by comparing the SFY 2017 Low Income Adult experience in the MCM program to actual SFY 2017 Transitional population experience. SFY 2017 is the first period where the MCO encounter data only includes transitional individuals since the Premium Assistance Program began in January 2016.

We applied the resulting 1.058 adjustment to both years of Low Income Adult base experience period in the Transitional rate development.

Appendix C shows the blending and experience adjustment step.

IV. FINAL CAPITATION RATE ADJUSTMENTS

This section of the report describes the final adjustments to calculate the NHHPP transitional population capitation rates from the projected July 2018 – December 2018 medical costs developed in Section III of this report.

CALCULATE FINAL PROJECTED MEDICAL COSTS

In this step, we use PMPM add-on adjustments for benefits not included in the base experience data. These benefits include:

- Expanded mental health services under the Community Mental Health Agreement
- Temporary CMHC fee schedule increase
- Gender dysphoria surgery benefit
- Facility specific FQHC adjustments
- Behavioral Health Crisis Treatment Center
- Chiropractic Benefit

Appendix D shows the details of our calculations.

Expanded Mental Health Services

DHHS is continuing its expansion of the mental health service capacity consistent with the Community Mental Health Agreement (CMHA). New Hampshire's SFY 2019 Medicaid budget includes approximately $18.0 million for additional Medicaid-funded services related to mobile crisis teams, crisis apartments, adult ACT teams, and supported employment.

The CMHA services are intended for all Medicaid beneficiaries in the adult behavioral health population (i.e., people identified as being in the Severe / Persistent Mental Illness, Serious Mental Illness, and Low Utilizer population). Accounting for the implementation of mandatory MCM enrollment under the 1915(b) waiver, approximately 25.6% of the CMHC expenditures for the adult behavioral health population will remain in the FFS program because they are not eligible to enroll in the transitional population due to retroactive eligibility, spenddown status, or Veteran's Administration eligibility. Therefore, we allocated 74.4% of the $18.0 million in CMHA funding ($13.4 million) to the managed care populations (MCM and NHHPP).

We developed the PMPM add-on by rate cell using the CMHC expenditures to allocate the CMHA funding to the MCM and NHHPP rate cells.

Please see Appendix H for more details on the development of the PMPM amount for the NHHPP transitional population.

Temporary CMHC Fee Schedule Increase

DHHS is temporarily increasing reimbursement rates by 8.5% for select services provided by CMHCs during SFY 2019 through a $3 million general fund investment. This investment will increase total CMHC revenue by approximately $5.6 million when matched with Federal funds across all Medicaid population and programs. The fee schedule increase applies to following twelve codes when the 'HW' modifier is present:

- T1016 - Case management
- H2019 - Therapeutic behavioral services, per 15 minutes
- H2015 - Comprehensive community support services, per 15 minutes
- H2020 - Therapeutic behavioral services, per diem
- 90847 - Family psychotherapy (conjoint psychotherapy) (with patient present)
- H2023 - Supported employment, per 15 minutes
- T1027 - Family training and counseling for child development, per 15 minutes
- H2018 - Psychosocial rehabilitation services, per diem
- S9485 - Crisis intervention mental health services, per diem
- 90846 - Family psychotherapy (without the patient present)
- H0034 - Medication training and support, per 15 minutes
- 90832 - Psychotherapy, 30 minutes with patient and / or family member

These codes, when paired with the 'HW' modifier, accounted for over 80% of all CMHC payments during SFY 2016 and SFY 2017.

Implementation of Gender Dysphoria Surgery Benefit

Effective July 1, 2017, DHHS implemented a gender dysphoria surgery benefit that covers male to female and female to male gender reassignment surgery. DHHS currently covers psychotherapy and hormone treatment.

We developed the expected cost of the gender dysphoria benefit using an estimated surgery cost of $50,000. We identified individuals with a gender dysphoria diagnosis in the MCO encounter data and assumed 10% would proceed with the surgery during July 2018 – December 2018. However, we assumed that individuals in a behavioral health population rate cell would not be candidates for surgery, based on discussions with DHHS. We also assumed that cases for children aged 18 or younger would be reviewed on a case-by-case basis and, therefore, assumed 5% of these identified individuals would proceed with the surgery during July 2018 – December 2018.

Based on the assumptions listed above, we estimate the cost of the gender dysphoria surgery benefit is $0.14 PMPM for the NHHPP transitional population.

Facility Specific FQHC Adjustments

As of April 1, 2018, White Mountain Community Center is classified as a Federally Qualified Health Center Look-Alike (LAL) with a per encounter rate of $152.87 for SFY 2019. We estimated the impact of the change in classification by repricing all encounters at this facility at the per encounter rate. We only repriced services subject to the per encounter rate payment as defined in the FQHC provider manual, Volume II dated January 1, 2018.

We estimate the impact of this change to be $0.07 PMPM.

Behavioral Health Crisis Treatment Center

On November 1, 2018, DHHS is implementing a Behavioral Health Crisis Treatment Center to serve any individuals in need of acute psychiatric treatment. The Behavioral Health Crisis Treatment Center is expected to provide services to adults ranging from crisis intervention to individual and group psychotherapy to psychoeducational services.

We used information provided by DHHS to estimate the cost of those services to the NHHPP transitional population at $201 or $0.03 PMPM. We allocated these costs by rate cell based on each rate cell's use of CMHC services since they are analogous to services provided by CMHCs.

Chiropractic Benefit

The estimated $2.36 PMPM cost for the chiropractic benefit was derived from commercial market pricing information, Medicaid reimbursement levels, and our judgment.

CALCULATE FINAL CAPITATION RATES BY RATE CELL

In this step, we apply adjustment factors to reflect an allowance for MCO administration / margin, and an allowance for state premium tax.

Appendix E shows the details of our calculations.

MCO Administration / Margin Allowance

The overall MCO administration / margin allowance composites to $56.30 PMPM for the NHHPP transitional population, which represents 11.3% of MCO revenue prior to the CMHC directed payment and premium tax allowance. The administration / margin allowance provides for a 9.8% load for administrative expenses ($48.82 PMPM) and 1.5% for profit and risk margin ($7.48 PMPM).

The administrative and margin load is consistent with the MCM low income adult rate cell.

CMHC Directed Payment

The SFY 2019 MCM and NHHPP capitation rates include a directed payment to CMHCs in the amount of $5 million across all programs and populations (MCM and NHHPP), pending approval by CMS. MCOs are required to pay these amounts directly to CMHCs according to criteria approved by CMS.

The directed payment is targeted to all Medicaid beneficiaries in the behavioral health population (members identified as SPMI, SMI, low utilizer, and SED children). We developed the PMPM directed payment by rate cell using the CMHC expenditures to allocate the total directed payment amount. Since these amounts are to be paid directly to the providers by the MCOs, we did not include an allowance for administrative expense or risk margin.

Premium Tax Allowance

The capitation rates include an allowance for the 2.0% premium tax collected by the New Hampshire Insurance Department.

V. SERVICE CATEGORY ASSIGNMENT

This section of the report provides information about the service category assignment used to create the cost models included in the NHHPP transitional population capitation rate development. This information can be used by participating MCOs to monitor their experience in a format and detail similar to the rate development process.

To prepare the attached cost models, we grouped claims into service categories. The service category assignment described below does not account for excluded or limited services. The next few paragraphs detail how the claim level detail is assigned to the service categories shown in Appendices A and B.

HOSPITAL INPATIENT

Hospital inpatient services are those items and services provided under the direction of a physician, furnished to a patient who is admitted to a general acute care or psychiatric medical facility, and professional services on a continuous basis that is expected to last for a period greater than 24 hours. An admission occurs when the Severity of Illness / Intensity of Services criteria set forth by the review contractor and approved by DHHS is met. Among other services, hospital inpatient services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological, and rehabilitative services in emergency or non-emergency conditions. Additional hospital inpatient services would include miscellaneous hospital services, medical supplies, and equipment.

The hospital inpatient claims are assigned a service category based on Diagnostic Related Group (DRG) codes. Milliman's algorithm classifies hospital inpatient claims using the following groupings of CMS v24 DRG codes.

Table 17
New Hampshire Department of Health and Human Services
Hospital Inpatient Service Groupings by DRG Code

Service Category	Diagnosis Related Group
Medical	'052'-'103','121'-'125','146'-'159','175'-'208','280'-'316','368'-'395','432'-'446','533'-'566','592'-'607','637'-'645','682'-'700','722'-'730','754'-'761','789'-'794','808'-'816','834'-'849','862'-'872','913'-'923','933'-'935','945'-'951','963'-'965','974'-'977'
Surgical	'001'-'042','113'-'117','129'-'139','163'-'168','215'-'265','326'-'358','405'-'425','453'-'517','573'-'585','614'-'630','652'-'675','707'-'718','734'-'750','799'-'804','820'-'830','853'-'858','876'-'876','901'-'909','927'-'929','939'-'941','955'-'959','969'-'970','981'-'989'
Maternity Delivery	'765'-'768', '774'-'775'
Maternity Non-Delivery	'769'-'770', '776'-'782'
Newborn	'795'
Psychiatric	'880'-'887'
Alcohol and Drug Abuse	'894'-'897'
Other	'998'-'999'

HOSPITAL OUTPATIENT

Hospital outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient / ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient / ambulatory care facilities include hospital outpatient departments, diagnostic / treatment centers, ambulatory surgical centers, emergency rooms, end stage renal disease (ESRD) clinics, and outpatient pediatric AIDS clinics (OPAC). Costs include facility charges only, and do not include professional charges unless performed by staff of the facility and billed on a UB-92 (hospital) claims form. All facility-billed items not part of an inpatient admission are considered hospital outpatient services.

The hospital outpatient claims are assigned a service category based on revenue codes. Milliman's algorithm classifies hospital outpatient claims using the following groupings of revenue codes.

Table 18
New Hampshire Department of Health and Human Services
Hospital Outpatient Service Groupings by Revenue Code

Service Category	Revenue Code
Emergency Room	'0450'-'0459'
Surgery	'0360'-'0369','0481','0490'-'0499','0750'-'0759','0790'-'0799'
Radiology	'0320'-'0330','0333','0339'-'0349','0350'-'0359','0400'-'0403','0404','0409','0610'-'0619'
Pathology / Lab	'0300'-'0319','0923','0925'
Pharmacy	'0250'-'0269','0331'-'0332','0335','0630'-'0637'
Cardiovascular	'0480','0482'-'0489','0730'-'0739'
PT / OT / ST	'0420'-'0449','0470'-'0479','0530'-'0539','0930'-'0932','0951'-'0952'
Psychiatric	'0513','0900'-'0905','0907'-'0919'
Alcohol and Drug Abuse	'0906', '0944'-'0945'
Other	'0001','0220'-'0249','0270'-'0279','0280'-'0289','0290'-'0299','0370'-'0379','0380'-'0399','0410'-'0419','0460'-'0469','0500'-'0509','0510'-'0512','0514'-'0521','0523','0526','0528','0529','0550'-'0569','0600'-'0609','0621'-'0624','0650','0655'-'0659','0670'-'0729','0740'-'0749','0760'-'0769','0770'-'0789','0800'-'0809','0810'-'0819','0820'-'0859','0860'-'0861','0880'-'0889','0920'-'0922','0924','0929','0940'-'0943','0946'-'0947','0948','0949','0990'-'0999','2100'-'3109'

PROFESSIONAL

Professional services are assigned to a service category using a condensed version of Milliman's *Health Cost Guidelines (HCGs)* grouping logic and other categories defined by DHHS. Professional services include the full range of preventive care services, primary care medical services, and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care, and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, and skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

COMMUNITY MENTAL HEALTH CENTER

Community Mental Health Center services are split into detailed service categories in order to provide more comprehensive medical cost information for the populations eligible for enhanced mental health services through the CMHCs. We reviewed the CMHC expenditures for those eligible for enhanced mental health services and developed the following service categories with the help of DHHS staff.

Table 19
New Hampshire Department of Health and Human Services
Community Mental Health Center Service Groupings by CPT Code

Service Category	CPT Code
Case Management	T1016
Long Term Support Service	H0034, H2011, H2015, H2019, H2020, T1027
Partial Hospital	H2001, H2018
Psychotherapy	90875, 90801, 90804, 90806, 90808, 90816, 90818, 90821, 90832, 90833, 90834, 90836, 90837, 90839, 90840, 90846, 90847, 90853
Evidence Based Practice	H2027
Medication Management	90805, 90807, 90809, 90817, 90819, 90862, H2010, M0064, T1001
Emergency Service 24/7	S9484
APRTP	S9485
Supported Employment	H2023
Harbor Homes	Provider NPI = 1699705079

PHARMACY

The pharmacy category includes pharmaceuticals as ordered by licensed prescribers and obtained at an outpatient pharmacy. Prescription drugs are identified by the presence of a National Drug Code (NDC) in the claims file. We used Medi-Span information to separate prescription drug expenditures into generic, single source brand, multi-source brand, specialty, and other scripts. We used a definition of specialty drugs consistent with Milliman's *HCGs*.

OTHER

The other service category includes the following services:

- Home health services including intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies
- Emergency transportation or acute care situation where normal transportation would potentially endanger the life of the patient
- Durable medical equipment that provides therapeutic benefits or enables a recipient to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and / or illnesses

Other services are also assigned a service category using CPT codes. Other unidentifiable services are assigned an "unknown" category of service.

VI. CMS RATE SETTING CHECKLIST ISSUES

This section of the report lists each item in the November 10, 2014 CMS checklist and discusses how DHHS addresses each issue and / or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rates Being Paid Under the Contract

The July 2018 – December 2018 managed care organization (MCO) capitation rate for the New Hampshire Health Protection Program (NHHPP) transitional population is developed using SFY 2016 and SFY 2017 MCO encounter data for the MCO eligible population, along with other information. DHHS sets one rate for all MCOs.

Please refer to this report for background on the program and more details around the rate development.

AA.1.1 – Actuarial Certification

The Actuarial Certification of the July 2018 - December 2018 transitional capitation rate is shown in Appendix K. The July 2018 - December 2018 transitional capitation rate has been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Appendix G includes a projection of total expenditures based on estimated enrollment and the July 2018 – December 2018 capitation rate.

AA.1.3 – Risk Contracts

The NHHPP program contract meets the criteria of a risk contract.

AA.1.4 – Modifications

The July 2018 - December 2018 rate documented in this report is the initial capitation rate for the transitional population for the July 2018 - December 2018 NHHPP contract period.

Note: There is no AA.1.5 on the Rate Setting Checklist

AA.1.6 – Limit on Payment to Other Providers

It is our understanding no payment is made to a provider other than the participating MCOs for services available under the contract.

AA.1.7 – Risk and Profit

The July 2018 - December 2018 transitional capitation rate includes a targeted margin of 1.5% for risk, profit, and contribution to reserves. We believe that this margin is appropriate given the variability of expenses under the program.

AA.1.8 – Family Planning Enhanced Match

DHHS does not claim enhanced match for family planning services for the population covered under this program at this time.

AA.1.9 – Indian Health Service (IHS) Facility Enhanced Match

DHHS does not claim enhanced match for Indian Health Services for the population covered under this program.

AA.1.10 – Newly Eligible Enhanced Match

The Transitional population is part of the newly eligible Medicaid population. Therefore, the rate is eligible for the enhanced Federal match under Section 1905(y).

AA.1.11 – Retroactive Adjustments

The July 2018 – December 2018 rate documented in this report is the initial capitation rate for the July 2018 – December 2018 NHHPP contracts and does not contain any retroactive adjustments.

AA.2.0 – Based Only Upon Services Covered Under the State Plan

The SFY 2016 and SFY 2017 MCO encounter base experience data includes a cost effective non-covered service that qualifies as an in lieu of service and meets cost effectiveness requirements. Please see Section III of this report for more details.

AA.2.1 – Provided Under the Contract to Medicaid-Eligible Individuals

The July 2018 – December 2018 capitation rate development methodology primarily relies on MCO encounter data for the transitional population.

AA.2.2 – Data Sources

The July 2018 – December 2018 capitation rate is developed using SFY 2016 and SFY 2017 MCO encounter claims and eligibility data.

Please refer to Sections II and III of this report for more details.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in this report. In addition, each item in the checklist is addressed in items AA.3.1 – AA.3.17 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rate includes the services covered under the NHHPP contract.

Section IV of this report documents the development of PMPM add-ons for gender dysphoria surgery services that were not offered to Medicaid eligibles in the base period but are part of the NHHPP contract for July 2018 – December 2018.

AA.3.2 – Administrative Cost Allowance Calculations

The capitation rate includes explicit administrative allowances. Please see Section IV in the report for more details regarding the administrative allowance calculation.

AA.3.3 – Special Populations' Adjustments

The July 2018 – December 2018 capitation rate methodology does include an adjustment for special populations based on a comparison of SFY 2017 data for the Low Income Adult population and the transitional population.

AA.3.4 – Eligibility Adjustments

The base data only reflects experience for time periods where members were eligible to enroll in a MCO.

AA.3.5 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. MCO recoveries are already reflected in the encounter data, therefore, no adjustment is necessary.

AA.3.6 – Indian Health Care Provider Payments

The MCOs are responsible for the entirety of any IHC payments, which are fully reflected in the claims data.

AA.3.7 – DSH Payments

DSH payments are not included in the capitation rate.

AA.3.8 – FQHC and RHC Reimbursement

The MCOs are responsible for the entirety of the FQHC and RHC encounter payments, which are fully reflected in the claims data.

AA.3.9 – Graduate Medical Education (GME)

GME payments are not included as part of the capitation rate.

AA.3.10 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The transitional population with an income over 100% of FPL must pay a $1 / $2 preferred / non-preferred copay for prescription drugs. The MCO encounter data reflects the copayment collection.

AA.3.11 – Medical Cost / Trend Inflation

Section III of this report documents the trend assumptions used to project the SFY 2016 and SFY 2017 base period costs to July 2018 – December 2018.

AA.3.12 – Utilization Adjustments

Utilization trend is included in AA.3.11.

AA.3.13 – Utilization and Cost Assumptions

The utilization and cost assumptions are appropriate for the population to be covered.

AA.3.14 – Post-Eligibility Treatment of Income (PETI)

Long term care services that are subject to patient liability are excluded from the transitional population capitation rate.

AA.3.15 – Incomplete Data Adjustment

The capitation rate includes an adjustment to reflect IBNR claims and underreported CMHC claims. Please refer to Section III of this report for more information on the development of these adjustment factors.

AA.3.16 – Primary Care Rate Enhancement

The July 2018 – December 2018 capitation rate is priced at levels consistent with current MCO reimbursement levels with considerations for expected NHHPP fee schedule changes.

AA.3.17 – Health Homes

Not Applicable.

AA.4.0 – Establish Rate Category Groupings

The July 2018 – December 2018 capitation rate uses only one rate cell to designate the eligible population.

AA.4.1 – Eligibility Categories

The eligibility categories included in the July 2018 – December 2018 capitation rate are defined in Section II of this report.

AA.4.2 – Age

Age is not used for certain rate category groupings.

AA.4.3 – Gender

Gender is not used for rate category groupings.

AA.4.4 – Locality / Region

Region is not used as a rating variable.

AA.4.5 – Risk Adjustments

The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.2 – Data Distortion Assessment

Our review of the base MCO encounter data did not detect any material distortions or outliers.

AA.5.3 – Data Smoothing Techniques

We determined that a data smoothing mechanism resulting from data distortions was not required.

AA.5.4 – Risk Adjustments

The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

DHHS will implement risk corridors for the transitional population as part of the risk mitigation process. Section II of this report includes an overview of the risk protection features.

AA.6.1 – Commercial Reinsurance

DHHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Stop-Loss Program

None.

AA.6.3 – Risk Corridor Program

DHHS will implement risk corridors for the transitional population as part of the risk mitigation process. Section II of this report includes an overview of the risk protection features.

AA.7.0 – Incentive Arrangements

None.

AA.7.1 – Electronic Health Records (EHR) Incentive Payments

DHHS has not implemented incentive payments related to EHRs for the July 2018 – December 2018 contract period.

VII. RESPONSE TO 2018-2019 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (MAY 2018)

SECTION I. MEDICAID MANAGED CARE RATES

1. General Information

A. Rate Development Standards

i. The rate certification included herein is for July 2018 – December 2018. The previous certification was for the SFY 2018 contract period. The six month rating period is necessary until the Premium Assistance Program (PAP) population moves from the individual exchange to Medicaid managed care on January 1, 2019. At that time, capitation rates will be developed for that new population, inclusive of the transitional population.

ii. This rate certification submission was prepared in accordance with 42 CFR §438.4, 438.5, 438.6, and 438.7.

a. Our actuarial certification letter signed by John Meerschaert, FSA, MAAA, certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(9)), 438.5, 438.6, and 438.7. The certification can be found in Appendix K.

b. The final and certified capitation rate can be found in Appendix D.

c. The items requested can be found in Sections I through IV of this report.

iii. Differences in capitation rates for covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered population.

iv. The July 2018 – December 2018 capitation rate uses only one rate cell to designate the eligible population and is developed to be actuarially sound.

v. The effective dates of changes to the Medicaid program are consistent with the assumptions used to develop the capitation rates.

vi. The rate certification submission does demonstrate that the capitation rate was developed using generally accepted actuarial practices and principles.

a. All adjustment to the capitation rate reflect reasonable, appropriate, and attainable costs.

b. No adjustments to the rate are performed outside of the initial rate setting process beyond those outlined in Section III of the report.

c. The final contracted rate match the capitation rate in the certification.

vii. The capitation rate included in this submission is certified for all time periods in which it is effective. No rates for a previous time period are used for a future time period.

viii. This rate certification conforms to the procedure for rate certifications for rate and contract amendments. The July 2018 – December 2018 rate documented in this report is the initial capitation rate for the July 2018 – December 2018 Transitional population as part of the NHHPP contract.

B. Appropriate Documentation

i. We believe the attached report properly documents all the elements included in the rate certification and provides CMS enough detail to determine that regulation standards are met.

Please see Sections I through IV of this report for the following details:

a. Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources,

b. Assumptions made, including any basis or justification for the assumption; and

c. Methods for analyzing data and developing assumptions and adjustments.

ii. We detail within our responses in this guide the section of our report where each item described in the 2018 – 2019 Medicaid Managed Care Rate Development Guide can be found.

iii. All services and populations included in this rate certification are subject to the enhanced Federal match under Section 1905(y).

iv. Please see Sections I and II of this report for the requested documentation.

2. Data

A. Rate Development Standards

i. Our report includes a thorough description of the data used and shows compliance with 42 CFR §438.5(c).

a. DHHS provided Milliman with validated encounter data and financial reports for at least the three most recent and complete years prior to the rating period.

b. The rate development methodology uses current MCO encounter data.

c. The data used is derived from the Medicaid population served under the NHHPP program.

d. The rate development methodology uses recent MCO encounter data for the Low Income Adult population.

B. Appropriate Documentation

i. Milliman requested and received a full claims and enrollment database from DHHS and the MCOs. This information is summarized in Appendices A1 - A2.

ii. A detailed description of the data used in the rate development methodology can be found in Section III of this report. Section III also includes comments on the availability and quality of the data used for rate development.

iii. The rate certification and attached report thoroughly describe any material adjustments, and the basis for the adjustments, that are made to the data. Please see Section III and IV of this report for more details.

3. Projected Benefit Costs

A. Rate Development Standards

i. The final capitation rate shown in Appendix F is based only upon services described in 42 CFR 438.3(c)(1)(ii) and 438.3(e).

ii. Variations in assumptions used to develop the projected benefit costs for covered populations are not based on the rate of federal financial participation associated with the covered population.

iii. Each projected benefit cost trend assumption is reasonable and developed in accordance with generally accepted actuarial principles and practices using actual experience of the Medicaid population and consideration of other factors that may affect projected benefit cost trends through the rating period.

iv. Please refer to Section III of this report for the details related to the treatment of in lieu of services.

v. The July 2018 – December 2018 capitation rate does not allow an institution for mental disease (IMD) to be used as an in lieu of service provider; therefore, the cost of all psychiatric services provided in IMDs is excluded from the capitation rate. In addition, the July 2018 – December 2018 capitation rate methodology excludes all claims and eligibility data for the portion of any month, when an individual age 21 to 64 had a psychiatric stay longer than 15 days in an IMD.

However, note that New Hampshire's Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver allows for the coverage of substance use disorder (SUD) services provided in an IMD.

vi. The July 2018 – December 2018 capitation rates do not allow an IMD to be used as an in lieu of service provider.

B. Appropriate Documentation

i. The various Exhibits included in this report document the final projected benefit costs by relevant level of detail and is consistent with how the State makes payments to the plans.

ii. Please refer to Section III of this report for the methodology and assumptions used to project contract period benefit costs. Section II of the report highlights key methodological changes since the previous rate development.

iii. The rate certification include a section on projected benefit cost trends in compliance with 42 CFR §438.7(b)(2). See Step 2 of Section III for details related to the development of projected benefit cost trends.

iv. This certification does not include additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act

v. Please refer to Section III of this report for the details related to the treatment of in lieu of services.

vi. Section III includes a description of how retrospective eligibility periods are accounted for in rate development.

vii. Section I documents the impact on projected costs for all material changes to covered benefits or services since the last rate certification.

viii. The rate certification includes an estimated impact of each covered benefit or service change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment for each change related to covered benefits or services.

4. Special Contract Provisions Related to Payment

A. Incentive Arrangements

i. Rate Development Standards

The July 2018 – December 2018 capitation rate methodology does not include any incentive arrangements.

ii. Appropriate Documentation

The July 2018 – December 2018 capitation rate methodology does not include any incentive arrangements.

B. Withhold Arrangements

i. Rate Development Standards

The July 2018 – December 2018 capitation rate methodology does not include any withhold arrangements.

ii. Appropriate Documentation

The July 2018 – December 2018 capitation rate methodology does not include any withhold arrangements.

C. Risk Sharing Mechanism

i. Rate Development Standards

The July 2018 – December 2018 Transitional population capitation rate will use the risk corridor arrangement described in Section II of this report.

ii. Appropriate Documentation

The July 2018 – December 2018 Transitional population capitation rate will use the risk corridor arrangement described in Section II of this report.

D. Delivery System and Provider Payment Initiatives

i. Rate Development Standards

Section IV of the report documents the CMHC directed payment that is new for SFY 2019 and is pending CMS approval.

ii. Appropriate Documentation

Section IV of the report documents the CMHC directed payment that is new for SFY 2019 and is pending CMS approval.

E. Pass-Through Payments

i. Rate Development Standards

The July 2018 – December 2018 capitation rate methodology does not include any pass-through payments.

ii. Appropriate Documentation

The July 2018 - December 2018 capitation rate methodology does not include any pass-through payments.

5. Projected Non-Benefit Costs

A. Rate Development Standards

i. The development of the non-benefit component of the July 2018 – December 2018 rate is compliant with 42 CFR §438.5(e) and includes reasonable, appropriate, and attainable expenses related to MCO administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, and cost of capital.

ii. The non-benefit costs included in the July 2018 – December 2018 capitation rate are developed as a percentage of projected benefit costs.

iii. Variations in assumptions used to develop the projected benefit costs for covered populations are not based on the rate of federal financial participation associated with the covered population.

iv. The Health Insurance Providers Fee (HIPF) is not included in the capitation rate documented in this report. DHHS will recalculate capitation payments for each MCO based on the actual amount of the HIPF for each plan and make gross adjustment payments to the MCOs to appropriately fund the HIPF and its related income tax impact once appropriate documentation can be provided.

B. Appropriate Documentation

i. Please refer to Section IV of this report for a detailed description of the data and methodology used to develop the projected non-benefit costs included in the capitation rates. The report includes a description of changes made since the last rate development.

ii. The projected non-benefit costs include appropriate consideration for administrative costs, taxes, licensing and regulatory fees, other assessments and fees, contribution to reserves, risk margin, and cost of capital.

iii. The Health Insurance Providers Fee (HIPF) is not included in the capitation rates documented in this report. DHHS will recalculate capitation payments for each MCO based on the actual amount of the HIPF for each plan and make gross adjustment payments to the MCOs to appropriately fund the HIPF and its related income tax impact once appropriate documentation can be provided. The MCO capitation rates documented in this report are actuarially sound prior to the application of the ACA health insurer fee provision.

6. Risk Adjustment and Acuity Adjustment

A. Rate Development Standards

i. The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

ii. The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

iii. Section III of this report documents the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered population.

B. Appropriate Documentation

i. The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

ii. The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

iii. The NHHPP transitional population capitation rate will not be risk adjusted due to the small number of members and significant enrollment turnover of the population.

iv. Please see Section III of this report for the requested documentation regarding the trend adjustment for opioid addiction population treatment costs to reflect the increased acuity of the covered population.

SECTION II. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS

This certification does not include rates for managed long-term services and supports (MLTSS).

SECTION III. NEW ADULT GROUP CAPITATION RATES

This certification only includes rates for the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

1. Data

A. A detailed description of the data can be found in Sections II and III of this report.

B. The transitional population was covered starting in September 2014 through the NHHPP Bridge Program. Since the Premium Assistance Program (PAP) began on January 1, 2016, the transitional population rates cover the population that moves from MCM to PAP (i.e., during their PAP carrier selection window). The July 2018 – December 2018 rate is based on the SFY 2016 and SFY 2017 MCM Low Income Adult experience, but is adjusted to the acuity level of the SFY 2017 transitional population.

2. Projected Benefit Costs

A. Our report includes a thorough discussion of issues related to the projected benefit costs for the new adult group:

   i. Data for the transitional population is available and is used to calculate an acuity adjustment to the SFY 2016 and SFY 2017 encounter data for the Low Income Adult population.

   ii. The base data and methodology used to calculate the July 2018 – December 2018 Transitional capitation rate is similar to the methodology used to calculate the SFY 2018 Transitional capitation rate.

   iii. Our rate setting assumptions are generally consistent between the SFY 2018 rate period and the July 2018 – December 2018 rate period.

B. We used SFY 2017 transitional population encounter data to make an acuity adjustment to the SFY 2016 and SFY 2017 encounter data for the Low Income Adult population to reflect the acuity level of the transitional population.

C. Table 2 in Section I of the report quantifies the impact of program changes implemented for July 2018 – December 2018.

D. Table 2 in Section I of the report quantifies the impact of program changes implemented for July 2018 – December 2018.

3. Projected Non-Benefit Costs

A. The assumptions used to develop the July 2018 – December 2018 non-benefit costs are consistent with those used to develop the SFY 2018 non-benefits costs.

B. Please refer to Section IV of this report for more details on the development of the non-benefit costs for the transitional population and how these assumptions compare to the MCM population.

4. Final Certified Rates

A. Please refer to Tables 1 and 2 in Section I of the report for a comparison of the SFY 2018 capitation rate to the July 2018 – December 2018 capitation rate.

5. Risk Mitigation Strategy

A. The July 2018 – December 2018 transitional population capitation rate will use the risk corridor arrangement described in Section II of this report.

B. The July 2018 – December 2018 risk mitigation strategy is the same as the SFY 2018 risk mitigation strategy.

APPENDICES A through E
State of New Hampshire
Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
July 2018 – December 2018 Capitation Rate Development

Appendix A1
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2016 MCO Encounter Base Experience Data

Eligibility Category: Low Income Adults

Member Months: 156,753

Benefits	Total Paid Dollars	Total Paid Admits	Total Paid Services	Admits Per 1,000	Utilization Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient							
Medical	$1,356,519	431	1,572	33.0	120.3	$3,147.38	$8.65
Surgical	1,567,292	218	975	16.7	74.6	7,189.41	10.00
Maternity Delivery	0	0	0	0.0	0.0	0.00	0.00
Maternity Non-Delivery	350,465	152	542	11.6	41.5	2,305.69	2.24
Well Newborn	0	0	0	0.0	0.0	0.00	0.00
Psychiatric	292,227	77	440	5.9	33.7	3,795.15	1.86
Alcohol and Drug Abuse	52,670	23	120	1.8	9.2	2,290.00	0.34
Other	0	0	0	0.0	0.0	0.00	0.00
	$3,619,173	901	3,649	69.0	279.3	$4,016.84	$23.09
Hospital Outpatient							
Emergency Room	$5,713,268		11,472		878.2	$498.02	$36.45
Surgery	1,683,481		1,914		146.5	879.56	10.74
Radiology	2,157,456		13,175		1,008.6	163.75	13.76
Pathology	1,007,351		82,228		6,294.8	12.25	6.43
Pharmacy	936,278		172,467		13,202.9	5.43	5.97
Cardiovascular	154,468		973		74.5	158.75	0.99
PT/OT/ST	521,056		17,361		1,329.0	30.01	3.32
Psychiatric	4,234		81		6.2	52.28	0.03
Substance Abuse	3,524		22		1.7	160.19	0.02
Other	2,496,542		94,678		7,247.9	26.37	15.93
	$14,677,659		394,371		30,190.4	$37.22	$93.64
Professional and Other State Plan Services							
Ambulatory Surgery Center	$151,548		493		37.7	$307.40	$0.97
Office Visits	3,065,295		53,039		4,060.3	57.79	19.55
Preventive Medicine	1,075,971		28,943		2,215.7	37.18	6.86
Maternity	1,247,653		5,115		391.6	243.91	7.96
Certified Midwife	32,412		210		16.1	154.04	0.21
PT/OT/ST	275,443		11,650		891.8	23.64	1.76
Psychiatric and Substance Abuse	1,499,259		17,695		1,354.6	84.73	9.56
Radiology and Pathology	1,848,304		75,804		5,803.1	24.38	11.79
Home Health and Private Duty Nursing	163,392		4,058		310.7	40.26	1.04
Ambulance	300,049		14,071		1,077.2	21.32	1.91
Non-Emergency Transportation	2,326,253		213,082		16,312.2	10.92	14.84
Opioid Treatment Program	1,791,129		175,257		13,416.5	10.22	11.43
Federally Qualified and Rural Health Clinics	2,836,124		22,666		1,735.2	125.13	18.09
Adult Medical Day Care	28,308		1,217		93.2	23.26	0.18
Personal Care	0		0		0.0	0.00	0.00
Durable Medical Equipment	748,651		42,810		3,277.3	17.49	4.78
Other	3,405,124		303,738		23,252.2	11.21	21.72
	$20,794,916		969,849		74,245.2	$21.44	$132.66
Prescription Drugs							
Generic Scripts	$4,580,994		197,052		15,085.0	$23.25	$29.22
Single-Source Brand	5,736,954		29,244		2,238.7	196.18	36.60
Multi-Source Brand	697,862		2,754		210.8	253.40	4.45
Specialty	3,073,322		1,025		78.5	2,998.36	19.61
Other	257		4		0.3	64.18	0.00
	$14,089,388		230,079		17,613.3	$61.24	$89.88
Mental Health Center							
Case Management	$101,712		284		21.7	$358.14	$0.65
Long Term Support Service	93,432		1,591		121.8	58.73	0.60
Partial Hospital	938		10		0.8	93.77	0.01
Psychotherapy	281,513		5,599		428.6	50.28	1.80
Evidence Based Practice	472		23		1.8	20.51	0.00
Medication Management	320		12		0.9	26.64	0.00
Emergency Service 24/7	282		12		0.9	23.46	0.00
APRTP	28,548		52		4.0	549.00	0.18
Supported Employment Services	3,397		115		8.8	29.54	0.02
Harbor Homes	5		1		0.1	5.00	0.00
Other	176,104		1,860		142.4	94.68	1.12
	$686,722		9,559		731.8	$71.84	$4.38
All Services	$53,867,859	901	1,607,507	69.0	123,060.1	$33.51	$343.65

Eligibility Category: Low Income Adults

Member Months: 132,295

Benefits	Total Paid Dollars	Total Paid Admits	Total Paid Services	Admits Per 1,000	Utilization Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient							
Medical	$1,421,996	439	1,767	39.8	160.3	$3,239.17	$10.75
Surgical	1,304,005	172	774	15.6	70.2	7,581.43	9.86
Maternity Delivery	0	0	0	0.0	0.0	0.00	0.00
Maternity Non-Delivery	253,087	120	402	10.9	36.5	2,109.06	1.91
Well Newborn	0	0	0	0.0	0.0	0.00	0.00
Psychiatric	313,638	71	459	6.4	41.6	4,417.44	2.37
Alcohol and Drug Abuse	278,753	94	989	8.5	89.7	2,965.46	2.11
Other	193	4	4	0.4	0.4	48.34	0.00
	$3,571,673	900	4,395	81.6	398.7	$3,968.53	$27.00
Hospital Outpatient							
Emergency Room	$4,778,934		8,931		810.1	$535.10	$36.12
Surgery	1,416,821		1,594		144.6	888.85	10.71
Radiology	1,804,995		11,188		1,014.8	161.33	13.64
Pathology	901,222		71,159		6,454.6	12.66	6.81
Pharmacy	615,216		179,905		16,318.5	3.42	4.65
Cardiovascular	123,373		747		67.8	165.16	0.93
PT/OT/ST	379,705		13,045		1,183.3	29.11	2.87
Psychiatric	42,918		232		21.0	184.99	0.32
Substance Abuse	42,044		374		33.9	112.42	0.32
Other	2,079,183		75,580		6,855.6	27.51	15.72
	$12,184,410		362,755		32,904.2	$33.59	$92.10
Professional and Other State Plan Services							
Ambulatory Surgery Center	$139,018		435		39.5	$319.58	$1.05
Office Visits	2,622,954		45,105		4,091.3	58.15	19.83
Preventive Medicine	873,864		21,860		1,982.8	39.98	6.61
Maternity	1,259,196		4,940		448.1	254.90	9.52
Certified Midwife	37,226		153		13.8	244.07	0.28
PT/OT/ST	224,367		9,578		868.8	23.43	1.70
Psychiatric and Substance Abuse	1,931,009		24,328		2,206.7	79.37	14.60
Radiology and Pathology	1,629,533		63,799		5,787.0	25.54	12.32
Home Health and Private Duty Nursing	128,100		3,520		319.3	36.39	0.97
Ambulance	257,072		12,357		1,120.9	20.80	1.94
Non-Emergency Transportation	2,912,535		202,959		18,409.7	14.35	22.02
Opioid Treatment Program	1,668,198		163,223		14,805.4	10.22	12.61
Federally Qualified and Rural Health Clinics	2,508,088		19,371		1,757.1	129.48	18.96
Adult Medical Day Care	14,864		627		56.9	23.71	0.11
Personal Care	28,474		5,277		478.7	5.40	0.22
Durable Medical Equipment	608,027		37,431		3,395.2	16.24	4.60
Other	3,001,928		267,440		24,258.5	11.22	22.69
	$19,844,453		882,403		80,039.5	$22.49	$150.00
Prescription Drugs							
Generic Scripts	$3,748,927		169,161		15,344.0	$22.16	$28.34
Single-Source Brand	5,420,199		26,369		2,391.8	205.55	40.97
Multi-Source Brand	290,731		1,080		98.0	269.20	2.20
Specialty	3,317,524		949		86.1	3,495.81	25.08
Other	328		8		0.7	40.98	0.00
	$12,777,708		197,567		17,920.6	$64.68	$96.58
Mental Health Center							
Case Management	$103,907		293		26.6	$354.63	$0.79
Long Term Support Service	87,208		1,304		118.3	66.88	0.66
Partial Hospital	0		0		0.0	0.00	0.00
Psychotherapy	201,849		3,490		316.6	57.84	1.53
Evidence Based Practice	190		15		1.4	12.66	0.00
Medication Management	1,279		48		4.4	26.64	0.01
Emergency Service 24/7	798		34		3.1	23.46	0.01
APRTP	39,528		72		6.5	549.00	0.30
Supported Employment Services	3,822		144		13.1	26.54	0.03
Harbor Homes	23		5		0.5	4.57	0.00
Other	184,566		1,906		172.9	96.83	1.40
	$623,168		7,311		663.2	$85.24	$4.71
All Services	$49,001,412	900	1,454,431	81.6	131,926.1	$33.69	$370.39

Appendix B1
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Projected Medical Costs by Rate Cell
Data Adjustments for SFY 2016 MCO Encounter Base Experience Data

Eligibility Category: Low Income Adults

Benefits	Per Capita Monthly Paid Cost	IBNR Adjustment	Reimbursement Adjustment	Utilization Trend Factors	Unit Cost Trend Factors	MCO Reimbursement Adjustment	Managed Care Savings Adjustment	Pharmacy Rebate Adjustment	PDN Adjustment	NEMT Adjustment	Stop Loss	Projected Per Capita Monthly Paid Cost
Hospital Inpatient												
Medical	$8.65	1.0000	1.0098	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	$8.73
Surgical	10.00	1.0000	1.0094	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	10.08
Maternity Delivery	0.00	1.0000	1.0000	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
Maternity Non-Delivery	2.24	1.0000	1.0710	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	2.39
Well Newborn	0.00	1.0000	1.0000	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
Psychiatric	1.86	1.0000	1.0327	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	1.92
Alcohol and Drug Abuse	0.34	1.0000	1.0938	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.37
Other	0.00	1.0000	1.0000	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
	$23.09											$23.50
Hospital Outpatient												
Emergency Room	$36.45	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	$39.58
Surgery	10.74	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	11.66
Radiology	13.76	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	14.94
Pathology	6.43	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	6.98
Pharmacy	5.97	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	6.49
Cardiovascular	0.99	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	1.07
PT/OT/ST	3.32	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	3.61
Psychiatric	0.03	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.03
Substance Abuse	0.02	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.02
Other	15.93	1.0001	1.0000	1.0560	1.0333	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	17.29
	$93.64											$101.67
Professional and Other State Plan Services												
Ambulatory Surgery Center	$0.97	1.0003	1.0041	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	$1.00
Office Visits	19.55	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	20.10
Preventive Medicine	6.86	1.0003	1.0651	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	7.52
Maternity	7.96	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	8.18
Certified Midwife	0.21	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.21
PT/OT/ST	1.76	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.81
Psychiatric and Substance Abuse	9.56	1.0003	1.0005	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	9.84
Radiology and Pathology	11.79	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	12.12
Home Health and Private Duty Nursing	1.04	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.07
Ambulance	1.91	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.97
Non-Emergency Transportation	14.84	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0430	1.0000	15.91
Opioid Treatment Program	11.43	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	11.75
Federally Qualified and Rural Health Clinics	18.09	1.0003	1.0561	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	19.64
Adult Medical Day Care	0.18	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.19
Personal Care	0.00	1.0003	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Durable Medical Equipment	4.78	1.0003	1.0017	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	4.92
Other	21.72	1.0003	1.0293	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	22.98
	$132.66											$139.21
Prescription Drugs												
Generic Scripts	$29.22	1.0000	1.0000	0.9431	1.0062	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	$26.83
Single-Source Brand	36.60	1.0000	1.0000	1.0027	1.0973	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	38.96
Multi-Source Brand	4.45	1.0000	1.0000	1.0027	1.0973	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	4.74
Specialty	19.61	1.0000	1.0000	0.9680	1.7333	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	31.83
Other	0.00	1.0000	1.0000	0.9431	1.0062	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	0.00
	$89.88											$102.36
Mental Health Center												
Case Management	$0.65	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	$0.70
Long Term Support Service	0.60	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.64
Partial Hospital	0.01	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.01
Psychotherapy	1.80	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.94
Evidence Based Practice	0.00	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Medication Management	0.00	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Emergency Service 24/7	0.00	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
APRTP	0.18	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.20
Supported Employment Services	0.02	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.02
Harbor Homes	0.00	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Other	1.12	1.0500	1.0000	1.0277	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.21
	$4.38											$4.73
All Services	$343.65											$371.47

Appendix B2
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Projected Medical Costs by Rate Cell
Data Adjustments for SFY 2017 MCO Encounter Base Experience Data

Eligibility Category: Low Income Adults

Benefits	Per Capita Monthly Paid Cost	IBNR Adjustment	Reimbursement Adjustment	Utilization Trend Factors	Unit Cost Trend Factors	MCO Reimbursement Adjustment	Managed Care Savings Adjustment	Pharmacy Rebate Adjustment	PDN Adjustment	NEMT Adjustment	Stop Loss	Projected Per Capita Monthly Paid Cost
Hospital Inpatient												
Medical	$10.75	1.0087	1.0099	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	$10.94
Surgical	9.86	1.0087	1.0104	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	10.04
Maternity Delivery	0.00	1.0087	1.0018	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
Maternity Non-Delivery	1.91	1.0087	1.0806	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	2.08
Well Newborn	0.00	1.0087	1.0018	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
Psychiatric	2.37	1.0087	1.0256	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	2.45
Alcohol and Drug Abuse	2.11	1.0087	1.0509	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	2.23
Other	0.00	1.0087	1.0018	1.0000	1.0042	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.00
	$27.00											$27.75
Hospital Outpatient												
Emergency Room	$36.12	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	$38.26
Surgery	10.71	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	11.34
Radiology	13.64	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	14.45
Pathology	6.81	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	7.22
Pharmacy	4.65	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	4.93
Cardiovascular	0.93	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.99
PT/OT/ST	2.87	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	3.04
Psychiatric	0.32	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.34
Substance Abuse	0.32	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	0.34
Other	15.72	1.0070	1.0000	1.0353	1.0211	1.0000	0.9950	1.0000	1.0000	1.0000	1.0000	16.65
	$92.10											$97.55
Professional and Other State Plan Services												
Ambulatory Surgery Center	$1.05	1.0053	1.0079	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	$1.08
Office Visits	19.83	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	20.28
Preventive Medicine	6.61	1.0053	1.0569	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	7.14
Maternity	9.52	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	9.74
Certified Midwife	0.28	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.29
PT/OT/ST	1.70	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.73
Psychiatric and Substance Abuse	14.60	1.0053	1.0146	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	15.15
Radiology and Pathology	12.32	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	12.60
Home Health and Private Duty Nursing	0.97	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.99
Ambulance	1.94	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.99
Non-Emergency Transportation	22.02	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.1623	1.0000	26.18
Opioid Treatment Program	12.61	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	12.90
Federally Qualified and Rural Health Clinics	18.96	1.0053	1.0445	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	20.26
Adult Medical Day Care	0.11	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.11
Personal Care	0.22	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.22
Durable Medical Equipment	4.60	1.0053	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	4.70
Other	22.69	1.0053	1.0261	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	23.82
	$150.00											$159.18
Prescription Drugs												
Generic Scripts	$28.34	1.0000	1.0000	0.9754	1.0924	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	$29.21
Single-Source Brand	40.97	1.0000	1.0000	1.0084	1.0493	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	41.94
Multi-Source Brand	2.20	1.0000	1.0000	1.0084	1.0493	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	2.25
Specialty	25.08	1.0000	1.0000	0.9839	1.4254	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	34.02
Other	0.00	1.0000	1.0000	0.9754	1.0924	1.0000	1.0000	0.9675	1.0000	1.0000	1.0000	0.00
	$96.58											$107.43
Mental Health Center												
Case Management	$0.79	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	$0.84
Long Term Support Service	0.66	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.71
Partial Hospital	0.00	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Psychotherapy	1.53	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.63
Evidence Based Practice	0.00	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Medication Management	0.01	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.01
Emergency Service 24/7	0.01	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.01
APRTP	0.30	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.32
Supported Employment Services	0.03	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.03
Harbor Homes	0.00	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	0.00
Other	1.40	1.0523	1.0000	1.0176	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.49
	$4.71											$5.04
All Services	$370.39											$396.95

Appendix C
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Projected Medical Costs by Rate Cell
Blended Projected SFY 2019 Medical Costs – Combined SFY 2016 and SFY 2017

Eligibility Category	SFY 2016 Projected Per Capita Monthly Paid Cost	SFY 2017 Projected Per Capita Monthly Paid Cost	Blended Projected Per Capita Monthly Paid Cost
NHHPP Transitional Population	$371.47	$396.95	$384.21
Opioid Addiction Treatment Trend Adjustment	1.1271	1.0309	
Transitional Population Experience Adjustment	1.0581	1.0581	
Projected Per Capita Monthly Paid Cost	$443.01	$432.98	$438.00

Appendix D
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Rate Cell Capitation Rates
Medicaid Care Management Benefit Add-Ons

Eligibility Category	NHHPP Transitional Population
Projected Per Capita Monthly Paid Cost	$438.00
PMPM Add-On for Expanded Mental Health Services	0.63
CMHC Fee Schedule Increase	1.41
Gender Dysphoria Adjustment	0.14
White Mountain Community Center	0.07
Behavioral Health Treatment Center	0.03
Chiropractic Benefit PMPM	2.36
Final Base Capitation Rate	$442.63

Appendix E
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Final Rate Cell Capitation Rates
Final Base Capitation Rate Development

Eligibility Category	NHHPP Transitional Population
Projected Per Capita Monthly Paid Cost	$442.63
TPL & Other Transactional Adjustment	1.0000
Seasonality Adjustment	1.0000
Adjusted Per Capita Monthly Paid Cost	$442.63
Administration Load	9.8%
Administration Expense Allocation	$48.82
Margin Load	1.5%
Margin Expense Allocation	$7.48
CMHC Directed Payment	$0.25
Premium Tax Adjustment	2.0%
Premium Tax Amount	$10.19
Final Base Capitation Rate	$509.37

APPENDIX F
State of New Hampshire
Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
Comparison of July 2018 – December 2018 Capitation Rates to SFY 2018 Capitation Rates

Appendix F
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Final Rate Cell Capitation Rates
Comparison of Composite Rates to SFY 2018 Capitation Rates

Eligibility Category	SFY 2019 Projected Member Months	SFY 2018 Rates	SFY 2019 Rates	Proposed Rate Change
NHHPP Transitional Population	6,915	$429.28	$509.37	18.7%

APPENDIX G
State of New Hampshire
Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
July 2018 – December 2018 Capitation Rate Development
Estimated Fiscal Impact

Appendix G
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
SFY 2019 Final Base Rate Cell Capitation Rates
Estimated Fiscal Impact of NHHPP Transitional Population

Eligibility Category	SFY 2019 Projected Member Months	Average Total Capitation Rate	Federal Capitation Rate Liability	Federal Capitation Total Cost Liability	State Capitation Rate Liability	State Capitation Total Cost Liability
NHHPP Transitional Population	6,915	$509.37	$478.81	$3,310,858	$30.56	$211,331

APPENDICES H through J
State of New Hampshire
Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
July 2018 – December 2018 Capitation Rate Development
Other Supporting Exhibits

Appendix H1
New Hampshire Department of Health and Human Services
Medicaid Care Management Capitation Rate Development
CMHC Services
Community Mental Health Agreement Add-on Development

CMHA Services	SFY 2019 Budgeted for Medicaid Services	Portion Allocated to Transitional Population	Portion Allocated to Step 1 Services	SFY 2019 Transitional Population Funding
Mobile Crisis Teams	$1,467,300	0.0%	74.4%	$355
Community Crisis Apartments	657,000	0.0%	74.4%	159
Assertive Community Treatment Teams	10,605,100	0.0%	74.4%	2,567
Supported Employment	5,250,000	0.0%	74.4%	1,271
Total CMHA Funding	$17,979,400			$4,353

Appendix H2
New Hampshire Department of Health and Human Services
Medicaid Care Management Capitation Rate Development
CMHC Services
Community Mental Health Agreement Add-on Development

Total SFY 2019 Allocated CMHA Funding	SFY 2019 Projected Member Months	PMPM Add-On
$4,353	6,915	$0.63

Exhibit I
New Hampshire Department of Health and Human Services
New Hampshire Health Protection Program - Transitional
Opioid Addiction Treatment Trend Adjustment Development

	Base Year Member Months				Projected SFY 2019 Member Months			Base Year PMPM Cost				Projected SFY 2019	
Base Data Year	Opioid Addiction Population	Non-Opioid Addiction Population	Total Population	Opioid Addiction Enrollment Trend	Opioid Addiction Population	Non-Opioid Addiction Population	Total Population	Opioid Treatment Cost	Other Cost For Opioid Addiction	Non-Opioid Addiction Population	Total	Projected Enrollment Mix PMPM	Rate Adjustment
SFY 2016	11,432	207,542	218,975	-52.3%	1,242	12,587	13,829	$532.44	$720.01	$377.45	$423.13	$476.91	1.1271
SFY 2017	993	9,770	10,762	11.9%	1,242	12,587	13,829	$737.14	$684.90	$413.78	$506.77	$522.43	1.0309

Appendix J
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

* A Hepatitis C supplemental drug is carved out if there's an accompanying treatment drug in the same month.

Hemophilia	Hepatitis C (Treatment)	Hepatitis C (Supplemental)*	Hyperammonemia (Carbaglu & Ravicti)
00026037220	00003001101	00004008694	52276031260
00026037230	00003021301	00004035009	52276031205
00026037250	00003021501	00004035239	75987005006
00026037920	00006307401	00004035730	76325010004
00026037930	00006307402	00004036030	76325010025
00026037950	00074006328	00004036530	
00026378220	00074308228	00074319716	
00026378225	00074309328	00074322456	
00026378330	59676022528	00074323956	
00026378335	61958150101	00074327156	
00026378550	61958180101	00074328256	
00026378555	61958220101	00085031402	
00026378660		00085119403	
00026378665		00085127901	
00026378770		00085129101	
00026378775		00085129701	
00026379220		00085129702	
00026379330		00085130401	
00026379550		00085131601	
00026379660		00085131602	
00026379770		00085131801	
00026382125		00085132301	
00026382225		00085132302	
00026382425		00085132704	
00026382650		00085135105	
00026382850		00085136801	
00053623302		00085137001	
00053761505		00085137002	
00053761510		00085138507	
00053761520		00085435301	
00053762005		00085435401	
00053762010		00085435501	
00053762020		00085435601	
00053763302		00093722758	
00053763402		00093722763	
00053765601		00093722772	
00053765602		00093722777	
00053765604		00093723281	
00053765605		00187200601	
00053766801		00187200605	
00053766802		00187200702	
00053766804		00187200706	
00053813001		00406204616	
00053813002		00406226042	
00053813004		00406226056	
00053813005		00406226070	
00053813102		00406226084	
00053813202		00781204304	
00053813302		00781204316	
00053813402		00781204342	
00053813502		00781204367	
00169701001		00781517728	
00169701301		16241006956	
00169702001		16241006976	
00169704001		16241007056	
00169705001		16241007076	
00169706001		16241033776	
00169706101		23490014105	
00169706201		38779025608	
00169720101		38779025609	
00169720201		42291071818	

Appendix J
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

Hemophilia	Hepatitis C (Supplemental)*
00169720501	42291071856
00169720801	42291071870
00169781001	42291071884
00169781501	49452622101
00169782001	49452622102
00169782501	49452622103
00169783001	49452622104
00169785001	49884004532
00944058101	49884007176
00944130110	49884033876
00944130210	49884034076
00944130310	49884085656
00944130410	49884085692
00944283110	49884085693
00944283210	49884085694
00944283310	51167010001
00944283401	51167010003
00944283410	51552081304
00944283501	51552081305
00944283510	51927167100
00944284110	54738095016
00944284210	54738095156
00944284310	54738095256
00944284410	54738095318
00944284510	54738095342
00944292102	54738095356
00944292202	54738095370
00944292302	54738095384
00944292402	54868452100
00944293001	54868452101
00944293101	54868452102
00944293201	54868452103
00944293301	54868488700
00944293501	54868488800
00944293502	54868503500
00944293503	54868503600
00944293504	54868503601
00944293801	59930152301
00944293802	59930152302
00944293803	59930152303
00944294001	59930152304
00944294002	62991207701
00944294003	62991207702
00944294004	62991207703
00944294010	63370021935
00944294110	63370021945
00944294210	63370021950
00944294310	63370021955
00944294410	64116003101
00944294510	64116003106
00944294610	64116003124
00944294810	64116003901
00944296010	64116003906
00944296110	64116003924
00944296210	65862020768
00944296310	65862029018
00944296410	65862029042
00944296510	65862029056
00944302602	65862029070
00944302802	65862029084
00944303002	66435010118
00944303202	66435010142

Appendix J
New Hampshire Department of Health and Human Services
NHHPP Transitional Capitation Rate Development
National Drug Codes for Carved-Out Prescription Drugs

Hemophilia
00944303402
00944304510
00944304610
00944304710
00944305102
00944305202
00944305302
00944305402
00944394002
00944394202
00944394402
00944394602
00944425202
00944425402
00944425602
00944425802
00944462201
00944462301
00944462401
00944462501
00944500101
00944500105
00944500110
00944755102
00944755302
13533066520
13533066530
13533066550
50242092001
50242092101
50242092201
50242092301
52769046001
53270027005
53270027105
53270027106
53270027205
53270027206
58394000101
58394000105
58394000106
58394000201
58394000205
58394000206
58394000301
58394000305
58394000306
58394000502
58394000504
58394000602
58394000604
58394000702
58394000704
58394000802
58394000803
58394001102
58394001104
58394001201
58394001202
58394001301
58394001302
58394001401

Hepatitis C (Supplemental)*
66435010156
66435010170
66435010184
66435010216
66435010356
66435010456
66435010556
66435010599
66435010656
66435010699
66435010756
66435010799
66435010856
66435010899
66435020115
66435020195
66435020196
66435020199
66435020209
66435020295
68084015011
68084015065
68084017911
68084017965
68382004603
68382004610
68382004628
68382026004
68382026007
68382026009
68382026010
68382026012
68382026028

Hemophilia

58394001402
58394001501
58394001502
58394001603
58394002203
58394002303
58394002403
58394002503
58394063303
58394063403
58394063503
58394063603
58394063703
63833038602
63833038702
63833051802
63833061502
63833061602
63833061702
63833089151
63833891501
64193022203
64193022204
64193022205
64193022302
64193022402
64193022502
64193024402
64193042302
64193042402
64193042502
64193044502
64208775201
64208775301
64406048308
64406048408
64406048508
64406048608
64406048708
64406048808
64406048908
64406080101
64406080201
64406080301
64406080401
64406080501
64406080601
64406080701
64406091101
64406092201
64406093301
64406094401
64406096601
64406097701
67467018101
67467018102
67467018201
67467018202
68516320002
68516320003
68516320004

Hemophilia

68516320005
68516320101
68516320202
68516320302
68516320401
68516320502
68516320602
68516360002
68516360004
68516360005
68516360006
68516360102
68516360202
68516360302
68516360402
68516360502
68516360602
68516460001
68516460002
68516460101
68516460201
68516460302
68516460402
68516460501
68516460601
68516460702
68516460802
68516460902
68516461002
68982013901
68982014001
68982014101
68982014201
68982014301
68982014401
68982014501
68982014601
68982018201
68982018202
69911047402
69911047502
69911047602
69911047702
69911047802
69911086402
69911086502
69911086602
69911086702
70504028205
70504028305
70504028405
70504028506
70504028606
70504028705
70504028805
70504028905
76125025020
76125050030
76125066730
76125066750
76125067250
76125067351

APPENDIX K
State of New Hampshire
Department of Health and Human Services
New Hampshire Health Protection Program Transitional Population
July 2018 – December 2018 Actuarial Certification

June 11, 2018

New Hampshire Department of Health and Human Services
Capitated Contracts Ratesetting
Actuarial Certification
July 2018 – December 2018 New Hampshire Health Protection Program Transitional Population
Capitation Rates

I, John D. Meerschaert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the New Hampshire Department of Health and Human Services (DHHS) to perform an actuarial certification of the New Hampshire Health Protection Program transitional population capitation rates for July 2018 – December 2018 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438; the CMS "Attachment A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting;" the 2018-2019 Medicaid Managed Care Rate Development Guide and Actuarial Standard of Practice (ASOP) 49.

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for July 2018 – December 2018. To the best of my information, knowledge and belief, the capitation rates offered by DHHS are in compliance with the relevant requirements of 42 § CFR 438.3(c), 438.3(e), 438.4 (excluding paragraph (b)(9)), 438.5, 438.6, and 438.7. The attached actuarial report describes the capitation rate setting methodology.

In my opinion, the capitation rates are actuarially sound, as defined in Actuarial Standard of Practice (ASOP) 49, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

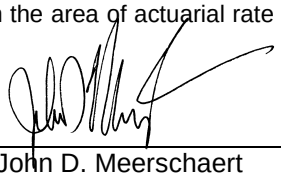
In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records and other information. A copy of the reliance letter received from DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

The capitation rates developed may not be appropriate for any specific MCO. Any MCO will need to review the rates in relation to the benefits provided. Each MCO should compare the rates with its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHHS. The MCO may require rates above, equal to, or below the actuarially sound capitation rates.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted managed care organization's situation and experience.

This Opinion assumes the reader is familiar with the New Hampshire Medicaid program, Medicaid managed care programs, and actuarial rating techniques. The Opinion is intended for the State of New Hampshire and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



John D. Meerschaert
Member, American Academy of Actuaries

June 11, 2018

RELIANCE LETTER

This report assumes that the reader is familiar with the State of New Hampshire's Medicaid program, its benefits, and rate setting principles. This report was prepared solely to provide assistance to DHHS to set July 2018 – December 2018 capitation rates for the New Hampshire Health Protection Program transitional population. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID SERVICES

Jeffrey A. Meyers
Commissioner

Henry D. Lipman
Director

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603-271-9422 1-800-852-3345 Ext. 9422
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May 29, 2018

Mr. John D. Meerschaert, F.S.A.
Milliman, Inc.
15800 Bluemound Road, Suite 100
Brookfield, WI 53005

Re: Actuarial Certification of SFY 2019 Capitation Rates for New Hampshire Medicaid Care Management and New Hampshire Health Protection Program Capitation Rates

Dear Mr. Meerschaert:

I, Henry Lipman, Medicaid Director for the New Hampshire Department of Health and Human Services, hereby affirm that the data prepared and submitted to Milliman, Inc. (Milliman) for the purpose of certifying the SFY 2019 New Hampshire Medicaid Care Management (MCM) program and New Hampshire Health Protection Program (NHHPP) capitation rates were prepared under my direction, and to the best of my knowledge and belief are accurate and complete. This data includes:

1. Computer files supporting the SFY 2019 capitation rate calculation, including, but not limited to:

    1) Technical Definition for NH MCM Data Book Services Scope V3.doc
    2) Reference Files.xls
    3) NH Provider Type Codes and Descriptions.xls
    4) Eligibility Category Detail.xlsx
    5) Medicaid CAHs.xls
    6) OP-RHC-FQHC Reimbursement Process as of 2-5-13.doc
    7) Provider Payment Algorithms2011.docx
    8) QA LOG Care management 111412012 w corrected date at top.xlsx
    9) Medicaid Extract and Claims Information.doc
    10) NH+Medicaid+rebranded+detailed+FQHC+Provider+Manual+2-1-18.pdf
    11) Newborn Reporting Procedures Guidance Statement 20121130.doc
    12) NH Care Management Contract Exhibit A 031612.pdf
    13) Executed Children's Hospital Agreement.pdf
    14) NH MCM Rate Cells Definition 2014-02-20.xls
    15) Community Mental Health Agreement 1.22.15.pdf
    16) CHB Enhanced Report for Milliman SFY 2017.xlsx
    17) Fiscal Impact Change of Scope & LAL SFY19.xlsx
    18) tblNHHLinked_to_MedicaidSFY2017v2.xlsx

2. Fee schedule files:

   1) CY/SFY/FFY 2016 fee schedules:
      - 2016 DRG Rate Sheet.xls
      - 2016 Outpatient Reimbursement Rates.xlsx
      - 100% CCR.xlsx
      - 2016 NH Fee Schedule - Covered Procedures.xlsx
      - 2016 NH Fee Schedule – Manually Priced Procedures.xlsx
      - Copy of Active ASC Codes Fee Schedule 2016- Update.xlsx
      - FQHC Annual Update FY2016.docx
      - 26/TC split: ATTFJV4Y.xlsx

   2) CY/SFY/FFY 2017 fee schedules:
      - 2017 DRG Rate Sheet.xls
      - Estimated 2018 DRG Rate Sheet.xls
      - Hospital OP 2018 Estimate.xls
      - ADH-REF-101 2017-01-05.xlsx
      - ADH-REF-102 2017-01-05.xlsx
      - Copy of NHCSR-OMBP-1-ASC+Fee+Schedule-Attachment1-20160105.xlsx
      - NHCSR-BBH-1-2017 Annual CPT Family Psychotherapy-Attachment1-20170106.xlsx

   3) CY/SFY/FFY 2018 fee schedules:
      - 2018 DRG Rate Sheet.xls
      - SFY 18 Hosp IP & OP.xls
      - 2018 NH Fee Schedule Covered Procedures 02232018.xlsx
      - 2018 NH Fee Schedule Manually Priced Procedures 02232018.xlsx
      - 2018 ASC Fee Schedule.xls
      - 2018 Hospice Rates worksheet-Final.xlsx
      - FQHC Based Rate SFY 2018.xls
      - SFY18 RATE CHANGE LOG.xlsx

   4) NHHPP fees schedules (from www.dhhs.nh.gov)
      - NHCSR-OMBP-1-Rate-Attachment-20150226.xlsx
      - NH-HPP+Fee+Schedule+Distribution+Revised+Effective+11-01-2016.xlsx
      - NHHPP+Fee+Schedule-08152017.xlsx

3. January 2010 – December 2017 Medicaid eligibility data and claims from MMIS, including:

   1) Biweekly claims data (facility, professional and drug).
   2) Biweekly enrollment data
   3) Provider reference files.
   4) Supplemental eligibility/ineligibility files

5) Additional Hospice and NEMT claims:
   - Copy of SFY 16 Hospice Claims Data for Milliman.xlsx
   - NEMT (Bridges) Detail for Milliman 2015.xlsx
   - CTS Encounter data- Milliman.xlsx
6) BCH Settlement:
   - CHB Figures for Milliman - SFY 2016.xlsx
7) Additional BDAS claims:
   - BDAS Likely Medicaid SFY2016-2017.accdb

4. Other supporting documentation, including:
   1) MCO contract
   2) Other computer files
   3) Conversations concerning supplied data

Signature

Henry D. Lipman
Name

Medicaid Director
Title

May 29, 2018
Date